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**An Incongruous Duality?
Care, Control & the Social World
of the Mental Health Worker**

Thesis submitted in accordance with the requirements of the University of
Chester for the degree of Doctor of Philosophy by:

PAUL JOHN TAYLOR

January

2011

Author's Declaration

I declare that this thesis is my own work and has not been submitted for an award other than this or at another higher education institution.

Signed

Paul John Taylor

Date

Dedication



The completion of this thesis comes at difficult time, as fellow colleague Dr. David Charles Ford sadly passed away following illness. David, programme leader for Sociology in the Department of Social Studies and Counselling at the University of Chester, has been an influential part of my academic life, both as one of my undergraduate lecturers and more recently as a departmental colleague.

David's personality, humour, professionalism and charisma brought lectures, meetings and the department to life, not least when I recall him encouraging a full lecture theatre of students to sing 'happy birthday' to him at the top of their voices.

It is without doubt that David's enthusiasm for his subject has left a mark on the memories of many of the students he has taught as well as those, myself included, who have had the privilege of working and learning alongside such a great educator, scholar and friend.

David was always on hand to offer advice and support and had participated on a number of occasions in the annual monitoring procedures of this PhD. It is with this that this thesis is dedicated to the memory of Dr. David Charles Ford- you will be truly missed.

“We trained very hard, but it seemed that every time we were beginning to form into teams, we would be reorganised. I was to learn later in life that we tend to meet any new situation by reorganising – and a wonderful method it can be for creating the illusion of progress while producing confusion, inefficiency and demoralisation.”

(Charlton Ogborn Jnr., 1957)¹

¹ The above quotation, taken from “Merrill's Marauders” in Harper’s Magazine, had been reproduced and was found hanging above a desk in one of the clinical areas of Hollybrook hospital.

Contents

CONTENTS.....	I
ABSTRACT.....	V
TABLES & FIGURES	VII
ABBREVIATIONS	VIII
STATEMENT OF ANONYMITY.....	X
ACKNOWLEDGEMENTS.....	XI
 INTRODUCTION	 1
 CHAPTER 1	
 WHY EXPLORE WORKING LIVES? THE POLICY CONTEXT	 7
 PART ONE: THE NATIONAL CONTEXT	 7
Recruitment and Retention	8
Psychiatric Care and Public Relations; Nursing Culture in the Spotlight	11
 PART TWO: THE LOCAL CONTEXT	 16
Service Modernisation	17
Financial Buoyancy in a Sea of Change	18
The Acute Care Model (ACM), Accreditation for Inpatient Mental Health Services (A.I.M.S.) & Star Wards.....	21
The Acute Care Model (ACM)	22
Accreditation for Inpatient Mental Health Services (AIMS).....	23
Star Wards.....	24
The Evolution of the Crisis Resolution Home Treatment Team (CRHT)	25
In-patient mental health services	26
The Patient Landscape	27
 Chapter Summary	 28
 CHAPTER 2	
 THEORISING MENTAL HEALTH WORK.....	 30
Legislative Reform and the Swing of the Care-Control Pendulum	31
‘Care versus Control’ within the ‘Total Institution’	37
The Visible & Invisible.....	45

Chapter Summary	47
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CHAPTER 3

CARE VERSUS CONTROL; THE SOCIAL & CULTURAL DIMENSIONS OF WORK	48
Herbert's 'Normative Order' of Police Culture	49
Organisational Culture & Occupational Sub-cultures	56
Role Conflict.....	60
The Working Personality	63
Performance Management	72
Workplace Humour.....	78
Chapter Summary	82

CHAPTER 4

EXPLORING & RESEARCHING WORKING LIVES.....	83
Aims and Objectives:	83
Philosophical, Theoretical and Methodological Approach.....	84
Research Methods; Work Life History and Narrative Inquiry	89
The Framework of a Narrative Approach to Data Collection.....	91
Fieldwork and Fieldwork Relations.....	102
Pilot Study.....	113
Chapter Summary	114

CHAPTER 5

BUREAUCRATIC CONTROL & RISK MANAGEMENT AT WORK	115
PART ONE: BUREAUCRATIC CONTROL & REGULATION.....	117
‘You don’t just chase paperwork, it chases you!’; Policy Sanctions in Mental Health Work	121
‘That’s how the tide has turned’; A New Organisational Culture	133
PART TWO: RISK MANAGEMENT.....	145
The ‘Crystal Ball’ of Risk Assessment.....	150
Chapter Summary	156

CHAPTER 6

COMPETENCE & MORALITY IN MENTAL HEALTH WORK	158
PART ONE: COMPETENCE	160
‘There’s no ‘I’ in Team’; Socialisation and the cultural dimensions of mental health work.....	160
Organisational Structuring of Emotion	173
Subcultural Structuring of Emotion	179
PART TWO: MORALITY	188
Chapter Summary	195

CHAPTER 7

THE PHYSICAL ENVIRONMENT & THE DICHOTOMY OF CARE VERSUS CONTROL	196
PART ONE: PHYSICAL ENVIRONMENT	197
Working Personalities & ‘Shelf Life’	198
Tradition, Community & Socialisation.....	206
Challenging Tradition	206
Training in the Clinical Environment	211
Environmental Change.....	213
PART TWO: CARE <i>VERSUS</i> CONTROL.....	216
‘Good Cop – Bad Cop’	217
Chapter Summary	223

CHAPTER 8

NORMATIVE ORDERS: A NEW THEORETICAL FRAMEWORK FOR EXPLORING MENTAL HEALTH WORK.....	225
The Normative Orders of Mental Health Work.....	226
The Total Institution	229
Extending the ‘Staff Perspective’	231
The Mortification of Self and Social Contamination in Mental Health Work	233
Staff Strata	236
Chapter Summary	240

CHAPTER 9

CONCLUSIONS ON THE DEVELOPING ROLE OF THE MENTAL HEALTH WORKER	242
Method Evaluation.....	242
Reflections on Researching Occupations.....	244
Theoretical Implications	249
Practical Implications.....	250
Limitations	251
Opportunities for the Future.....	251

APPENDICES

Appendix (i).....	254
Overview of Prison Officer Typologies	
Appendix (ii).....	257
Interview Schedule	
Appendix (iii).....	261
Theme Development	
Appendix (iv).....	268
Trust Access Approval	
Appendix (v)	270
Participant Information Sheet	
Appendix (vi).....	273
Participant Consent Form	
Appendix (vii).....	275
Recruitment Demographic	
Appendix (viii).....	277
Participant Summary Impressions	
Appendix (ix).....	293
Ward/Department Overviews	
Appendix (x)	300
Bureaucratic/Structural Organisation of NHS Trusts	
Appendix (xi).....	302
Clinical Risk Assessment Example	
Appendix (xii).....	304
Overview of Pay Scales	
REFERENCES	306

Abstract

The contemporary mental health profession is facing a crisis of recruitment and retention. Services provided are complex, practically and conceptually. On one hand, assessments and treatments are provided, but on the other, staff become responsible for the administration of coercive security discourses and arrangements. This complex phenomenon can leave mental health personnel vulnerable to criticisms in exactly *how best* they should discharge their duties within an occupational remit of duality. Working in the *correct* or most appropriate way is a constant challenge for staff as they must meet with approval from both managers and colleagues negotiating a path between formal rules and informal norms.

This exploratory study was undertaken within a mental health NHS Trust in the North of England. It interviewed twenty participants from a range of areas of work, namely hospital wards, occupational therapy departments and the community setting. A narrative interviewing technique has been used to collect occupational histories and stories which have been used in an attempt to illuminate the contemporary issues facing clinical staff.

Findings suggest that their contemporary care delivery is much more complex than previously known and that there is a diverse range of background and conceptual challenges which workers face in addition to their organisationally prescribed practical mandates of work. Six normative orders of work have emerged from data that has been collected; bureaucracy, risk management, competence, morality, physical environment and care versus control.

Participant reflections on professional autonomy and responsibility shed light on the perceived rationality of policies and procedures and ‘governance at a distance’ taking place in response to bureaucratic and risk reduction imperatives. Indeed, such work is demanding and the management of a

professional ‘performance’, and the self regulating and adaption of emotion have been seen to be an important dimension in the observation of occupational competence and work-based socialisation processes. Furthermore, personnel are engaged in a complex and fluid role duality where they must personally reconcile their role as care provider whilst also maintaining levels of physical security in a contemporary and technologically advanced healthcare environment.

In this thesis, it is argued that these normative aspects of work typify the social nature of mental health work and, in addition, take place under the auspices of Goffmanesque theorisations of the ‘total institution’, ‘mortification of self’ and ‘social contamination’.

These findings draw particular attention to an under acknowledged aspect of mental health based inquiry where the formal and informal spheres of work are observed to co-mingle within the environment of psychiatry. In doing so, questions arise over the rationality of some systems of work which ‘shop-floor’ staff are engaged within, yet, at times, have very little opportunity to shape as individual practitioners.

Tables & Figures

Tables

<i>Table 1</i>	Typology of officers according to attitudes towards officers and inmates (Kauffman, 1988, p.249)	Pg.67
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Figures

<i>Figure 1</i>	Overview of research methodology and method	Pg.91
<i>Figure 2</i>	Structure of BNIM interviewing	Pg.93
<i>Figure 3</i>	Hierarchy of access gatekeepers	Pg.108
<i>Figure 4</i>	Pyramid of governance	Pg.124
<i>Figure 5</i>	Tripartite structuring of emotion	Pg.180
<i>Figure 6</i>	Compression of expectations facing mental health personnel	Pg.184
<i>Figure 7</i>	Influences on the fulcrum of role duality	Pg.221
<i>Figure 8</i>	The normative orders of mental health work	Pg.228

Abbreviations

A.C.M.	Acute Care Model
A.I.M.S.	Accreditation for Inpatient Mental Health Services
A.O.T.	Assertive Outreach Team
B.N.I.M.	Biographical Narrative Interpretive Method
C.A.R.D.S.	Clinical Assessment of Risk Decision Support
C.A.R.S.O.	Clinical Assessment of Risk to Self and Others
C.C.A.W.I.	Centre for Clinical & Academic Workforce Innovation
C.C.T.V.	Closed Circuit Television
C.I.P.	Cost Improvement Programme
C.M.H.T	Community Mental Health Team
C.O.T	College of Occupational Therapists
C.P.N.	Community Psychiatric Nurse
C.R.H.T.	Crisis Resolution Home Treatment
C.R.E.S.	Cash Releasing Efficiency Savings
C.S.P.	Community Specialist Practitioner
C.S.W.	Clinical Support Worker
C.T.O.	Community Treatment Order
C&R	Care & Responsibility / Control & Restraint
DoH.	Department of Health
D.S.P.D.	Dangerous Severe Personality Disorder
E.C.T.	Electro Convulsive Therapy
E.I.T.	Early Intervention Team
G.P.	General Practitioner
H.M.P	Her Majesty's Prison
H.R.	Human Resources
L.A.P.D.	Los Angeles Police Department
L.R.E.C.	Local Research Ethics Committee
M.D.T.	Multi Disciplinary Team
M.H.A.	Mental Health Act
N.I.C.E.	National Institute for Clinical Excellence

N.I.M.H.E.	National Institute for Mental Health in England
N.H.S.	National Health Service
N.H.S.L.A.	National Health Service Litigation Authority
N.M.C.	Nursing & Midwifery Council
O.T.	Occupational Therapist
P.C.T.	Primary Care Trust
P.D.	Personality Disorder
P.D.U.	Personality Disorder Unit
P.E.T.	Psychiatric Emergency Team
P.I.C.U.	Psychiatric Intensive Care Unit
P.O.A.	Prison Officer's Association
Q.C.	Queen's Council
R.C.Psych	Royal College of Psychiatrists
R.M.N.	Registered Mental Health Nurse
R.M.O.	Responsible Medical Officer
S.H.A.	Strategic Health Authority
S.H.S.A	Special Hospital Service Authority
S.Q.U.I.N.	Single Question to Induce Narrative
S.N.	Staff Nurse
T.A.G.	Threshold Assessment Grid
T.I.	Technical Instructor (Occupational Therapy)
T.O.I.L.	Time Off In Lieu
T.Q.U.I.N.	Theory Questions aimed at Inducing Narrative
U.K.	United Kingdom
WW1/2	World War 1 / World War 2

Statement of Anonymity

Those who have kindly contributed to this research study have had their identities protected through the use of fictitious names. Any reference to individuals or members of staff that has been made, in name, by participants have also been allocated an alias.

Hollybrook hospital and the names of the wards/departments are pseudonyms for premises within a mental health NHS Trust in the North of England.

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I would like to show my gratitude to my family and partner Sian, who have provided support when things got tough and have listened, without objection, to rants, moans and expletives of frustration. They have listened to the ‘highs’ and the ‘lows’, and have always been forthcoming in providing the ‘confidence push’ needed from time to time. Further thanks go to a good friend of mine, Ross McGarry, who has been undertaking his PhD simultaneously, and has always been obliging for long sessions of ‘chewing the fat’.

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Finally, I am indebted to those mental health professionals who have taken part in this research. Without their input, this thesis would have not seen the light of day and has provided myself, and those who read this thesis, a much more developed understanding of the work that they undertake.

INTRODUCTION

In the public domain, mental health services receive little attention, except for those who may use these services, write about them, or work within them. This is upheld by a concentration by documentary and drama writers with the seductive, unpredictable and exciting nature of the general health care setting, illustrated in television programmes such as *Casualty*, *Holby City*, *Hospital 24/7* and *The Real A&E*. Soap operas such as *EastEnders* have only just begun to introduce story lines where mental illness is a salient issue, and yet, we rarely see a glimpse into the institutional environments of mental health care; that is until things go wrong.

Historically located, and often contemporarily too, mental health services often reside on the peripheries of towns and cities. Similarly, it lies on the peripheries of the public imagination except for when high profile cases such as the Michael Stone case are projected into society's consciousness. It is therefore unclear for many how such a population is cared for, and what it is like for those who have to do it.

Those with mental illness and distress have long been vilified in the public imagination as socially, morally, and at times, criminally deviant. For many outside of the profession, the work of the mental health professional is viewed as that which maintains public protection and safeguards against assaults on civil society. Yet, whilst such obligations may be manifested in a practitioner's role at times, their work is much more complex, particularly where they must deliver *care* within dominant opposing *coercive* discourses.

In this thesis I hope to extend and build upon existing sociological analyses of work. The contemporary mental health worker is subject to a range of political, organisational and moral imperatives within their role-set. This thesis has a broad aim to provide a sociological understanding of what constitutes mental health work, how mental health work is done, and the effects that it has on those

who do it. It will address specifically the nature and arrangement of work, how workers experience specific aspects and how technology and policy developments impact upon their work.

This thesis explores how this particular group of mental health nurses and occupational therapy staff negotiate their work and the frames of social action which they operate within and experience. It also looks towards not only the formal rules of work, but also the social constructions of informal practices and expectations.

In the face of rapid organisational developments, the responses of workers toward the constraints, contradictions and rationality of policy and procedure emerge as an important evaluative tool. Moreover, the exploration of social relations and management of emotions in the workplace are influential in determining how to *get the job done* and this thesis examines how occupational subcultures are important in shaping how work is completed.

In a deliberate attempt to hear the *voice* of those in the field, the narrative methodology tells the stories of workers themselves ‘as stories have much to offer as a way of understanding’ (Fairbairn and Carson, 2002, p.7). It highlights the obstacles that workers face in delivering services to a diverse clientele, whilst at the same time meeting organisationally determined levels of efficiency and effectiveness. Governmental tendencies are firmly entrenched in an economic discourse of producing a range of effective services at a reduced cost, and as this research has been conducted during a period of economic recession, this situation remains persistent and provocative in the daily lives of mental health workers. Workers at all hierarchical levels are increasingly exposed to greater demands on cost effectiveness and risk minimisation. The bureaucratic function of public service workers in the National Health Service is also becoming increasingly evident. This thesis is structured to provide some illumination of the unexplained effects of how the multivariate role of contemporary mental health workers is managed on the shop-floor, and the costs, considerations and strategies that such a role attracts.

Operating at the interface of medical and legal services and in an environment riven with dilemmas around the twin imperatives of care (therapy) and control (security), mental health nursing has undergone major changes in recent years in the United Kingdom and elsewhere. The shifts of service provision from predominantly institutional to community based care, technological advances, increased professionalism, shifts in policy and in clinical practice have all left practitioners with a dilemma of an ill-defined role.

Mental health nursing can be seen as an occupation in which extremes exist. Whilst much of the job may be considered domestic in nature, mental health nurses work within an environment where there is potential for violence and where there is the necessity to perform and manage emotion on a daily basis.

Very little is known about how mental health nurses construct an understanding of their role and the strategies that enable them to perform their work duties. This thesis draws upon one of the central themes of the sociology of occupations in that it aims to provide an in-depth analysis of the effect of mental health work on an employee's outlook on the world. In so doing, it represents a deliberate attempt to put forward an approach to understanding mental health work that is grounded in the identity and consciousness of practitioners themselves through the use of the worker's own narrative.

The findings of this study are presented as a series of six normative orders. These normative orders represent the core theory of this thesis and are utilised as an analytic framework by which the institutional and community-based personnel experience their work. Chapters 5, 6 and 7 each present findings that are structured into the normative orders of mental health work (bureaucratic control, risk management, competence, morality, the physical environment and care versus control).

Spending time making sense of daily work routines and the demands placed upon staff is often a task overshadowed by a need to present as a 'professional'

and maintain efficiency and continuity in an eventful and busy work environment. Taking time out of duties and reflecting upon aspects of the job and the challenges that employees face is often only restricted to co-worker discussions and/or clinical supervision. In light of this, there is little research evidence that highlights how mental health work is 'done' and the decisions involved in 'doing it', that have been derived from oral histories and narratives of the workers themselves.

As a researcher, my interest in promoting the 'voice' of mental health workers has developed from my own experiences in the field. For the last ten years, I have experienced various healthcare environments, the majority of which have been within NHS mental health in-patient services. During this relatively short time, I have observed many changes to the structure and landscape of mental health care and heard various interpretations by staff on how best to do their job. Spending some years working night shifts within a hospital setting led to a situation whereby the 'story' emerged as a critical tool in workers making sense of their occupational role. During the more 'quiet' times of the night shift, nurses and other healthcare workers would often reminisce and tell stories of their past occupational experiences. Often these stories of the past would be used to inform upon and substantiate their current experiences, not least those stories that referred to 'the good old days'. It appeared to me that talking and thinking about past experience went some way to making sense of their job in the current climate and workers were usually keen to talk about the social realities which they face routinely.

With occupational experiences in mind, and a strong sense of responsibility in representing this particular group, this research embarked upon exploring the dimensions of mental health work and how it is done. By doing so, this thesis provides deeply emotive representations provided by the voice of the nursing and allied staff themselves. The social realities of care are set against oral histories of occupational careers, thus providing an insight into what it means to be a member of the care team in contemporary mental health services and

understanding, from their own point of view, what social life is like in such an occupation.

It has not been my intention to measure, for example, levels of staff morale, job satisfaction or burnout amongst healthcare staff, but rather to embark upon collecting a more holistic ‘world view’ of an occupation and the means by which work is undertaken.

The thesis is set out as follows:

Chapter 1 (Part One) provides an insight and justification to analysis of this particular area of study through the acknowledgement of policy initiatives that is grounded in the identification of problems in the recruitment and retention of mental health personnel. Further, this chapter examines some of the negative attention mental health services have attracted over recent years and the potential impact these have had.

Chapter 1 (Part Two) provides a detailed background of where the research study has taken place. It provides information on the structure of services and some of the economic and policy challenges contemporary services face.

Chapter 2 puts forward theoretical perspectives concerning the character of the environment which mental health care takes place within. Environmental, political and legislative issues are presented in the context of the delivery of psychiatric care that engenders a duality of security and treatment.

Chapter 3 builds upon literature analysis of Chapter 2 with specific reference to the social and cultural dimensions of work. This chapter engages with a range of sources that provide some illumination on how professionals from other occupations and disciplines (police work for example) experience their work.

Chapter 4 explains the methodological and practical approaches that has been undertaken in order to collect and analyse data of the lived realities of mental health professionals.

Chapter 5 is the first of three chapters that present the findings of the research and analysis. Categories and emergent themes drawn from the data are presented, with each chapter providing two core themes. Chapter 5 provides findings grounded in the themes of bureaucratic control and risk management.

Chapter 6 is the second chapter where findings are presented. This chapter deals specifically with perspectives of staff competence and morality. Here a close examination of occupational subcultures is undertaken.

Chapter 7 is the final findings chapter that offers an explanation of the importance of the physical environment in daily practice. It also examines the ideologically opposed mandates of care and control, and the duality of the mental health practitioner's role-set.

Chapter 8 provides a further discussion of the findings and presents a core theory developed from the analysis of data. It links and builds upon existing theoretical perspectives in a manner that presents an effective and unique way of examining mental health work currently and into the future.

Chapter 9 is a concluding chapter that draws together the main components of the research. It discusses both the practical and theoretical contributions in addition to the implications for the future of mental health care.

CHAPTER 1

WHY EXPLORE WORKING LIVES? THE POLICY CONTEXT

This chapter is divided into two sections which provide the policy dimensions to contemporary work in mental health care. Work takes place within a complex backdrop of reform and adaptation and this chapter presents *some* of the fundamental influences at the time of writing. Part one undertakes a broad analysis of current policy developments and initiatives whilst Part two deals with particular policy change at the research site, Hollybrook hospital.

Part One: The National Context

As part of the National Institute for Mental Health in England's (NIMHE) National Workforce Programme and the NIMHE New Ways of Working (NWW) initiative, in April 2006, the Department of Health published the Chief Nursing Officer's review of *Recruitment and Retention of Mental Health Nurses; Good Practice Guide*. This document details information put forward by several contributory studies² in respect of providing a structured good practice guide on recruiting and retaining the mental healthcare workforce. Since this publication, and to date there has been no superseding policy in terms of reviewing the current workforce condition or good practice guidance. Human resource management in mental healthcare is a significant problem with a 'workforce under great pressure' (Sainsbury Centre, 2000, p.1). Statistically, the number of people working in psychiatry had risen from 39,109 in 1997 to 47,390 in 2005 (Department of Health, 2006, p.7), yet, this is not the entire

² Sainsbury Centre for Mental Health (2000) *Finding and Keeping – A Review of Recruitment and Retention in the Mental Health Workforce*.

NIMHE Workforce Programme (2004) *Mental Health Workforce Recruitment and Retention Research Project*.

Centre for Clinical and Academic Workforce Innovation (2004) *Time To Act – Choosing to Work in Mental Health*

Audit Commission (2002) *Recruitment and Retention – A Public Service workforce for the 21st Century*

Department of Health (2002) *NHS Plan – Improving Working Lives Programme*.

extent of the situation facing workforce planners. In terms of nurses in general, that is those registered ³ and working in all nursing settings, 60% of those staff were aged forty or over, and more than one in four is aged over fifty years (Department of Health, 2006, p.7), indicating in general terms that nursing is experiencing an aging workforce. Department of Health (2006) statistics also publicise that vacancy rates for community psychiatric nursing posts, in England vary from 0% to 7.4% and other areas of psychiatry (for example, in-patient) the vacancy rate varied between 3.6% and 16.8% (Department of Health, 2006, p.7).

The challenges, demands and pressures of working in psychiatry have evidently left their mark upon employment levels. At the beginning of this millennium, 85% of NHS Trusts in England and Wales reported difficulties in recruiting and retaining staff and that 21% of nursing posts in mental health were considered as 'hard to fill' (Sainsbury Centre, 2000, p.1). In light of these problems, the media and trade unions have publicised some of the more significant events affecting mental health workers that may contribute to such recruitment and retention problems. Violence at work, claims of institutional racism (for example, David 'Rocky' Bennett Inquiry) and pay disputes⁴, aside from the occupational and organisational duties involved in direct nursing care, are illustrative of factors affecting workforce management.

Recruitment and Retention

Over the last decade both the Department of Health and other commissioned research agencies (for example, Sainsbury Centre for Mental Health) have undertaken a review of the problems involved in the recruitment and retention of mental health nurses and workers. When investigating staff cultures, what follows are important representations in research and policy of the problems and

³ Professional Registration with the Nursing and Midwifery Council (NMC UK)

⁴ April 2007, annual pay-rise of 2.5% staggered with a postponement of 1% for further 7 months. See appendix vi for an overview of Agenda for Change pay scales

challenges facing contemporary psychiatric care in terms of maintaining a buoyant workforce.

Reviews of National Health Service mental health workforces indicate that it is a system under great pressure both for the workers themselves and also for workforce planners. In the year 2000, 85% of NHS Trusts reported difficulties in recruiting (Sainsbury Centre, 2000) with a culture of competition between trusts for employees rather than any collaboration (NIMHE Workforce Planning, 2004). Problems have been highlighted in the recruitment of staff in that barriers to employment exist such as employer attitudes and financial rewards and salaries (McDonald, McQuade and Patel, 2004). In addition to problems in recruiting to the discipline, retaining and encouraging returners to the occupation is equally difficult. The problems of staff shortages and staff pressures co-exist and the causation behind each of them emerging from a continuous cycle between the two phenomena. Understaffing, high turnover, excessive use of agency staff, long hours, extensive paperwork and routine risk of violence have all contributed to employees experiencing low morale, poor levels of job satisfaction and staff discontent (Sainsbury Centre, 2000).

Several projects and reports (Sainsbury Centre for Mental Health, 2000; Audit Commission, 2002; National Institute for Mental Health in England (NIMHE), 2004; Centre for Clinical and Academic Workforce Innovation (CCAWI), 2004) have contributed to the latest Department of Health white paper entitled 'Recruitment and Retention of Mental Health Nurses; Good Practice Guide' (2006). This good practice guide endeavours to set out the key objectives in recruiting, retaining and encouraging returners back to the mental health profession. This report offers medium-to-long term guidance and through implementation, aims to answer the question of 'how can mental health nursing best contribute to the care of service users in the future?' The report provides this guidance through consolidation and presentation of examples of best practice and presents seventeen areas for improvement under four sections; recruitment, retention, approaching retirement and 'returners'. Implementation

of this 'good practice guide' is not mandatory and adoption of this document is regarded as best utilised on a local and discretionary basis.

The Recruitment and Retention of Mental Health Nurses; Good Practice Guide does not detail many of the underlying reasons *why* psychiatry is problematic in maintaining a robust workforce, and so it is necessary to look beyond this guidance and towards the research reports which inform it. Issues of job satisfaction and workplace stress are perhaps some of the popular and widely used indicators of recruitment based issues. Yet, there is a broad range of further organisational and environmental issues that present themselves in recognising some of the challenges that recruiters face. Identifying and linking findings from several viewpoints allows for a holistic approach to unveiling the formal and informal aspects of work in challenging environments.

Nursing research, from all sub-disciplines, reveals an abundance of literature on job satisfaction. As cited above and additionally by Buchan (2000) recruitment and retention of mental health staff is a persistent problem. Workforce planning studies and recommendations all at some point refer to job satisfaction as one of the most influential aspects of retaining employee numbers. Addressing this problem is beneficial in a two-fold way. The perceived lack of job satisfaction and morale may impact upon nursing staff and their service users, thus any improvements achieved in these fields may have positive results for staff retention and user confidence (Ward and Cowman, 2007). Literature in this field suggests that environment plays a big part in levels of job satisfaction. Ward and Cowman (2007) suggest that institutional based nursing staff are less highly valued than their community based counterparts. Data collected by Ward and Cowman (2007) suggest that differences in management and spending between hospital and community impact on levels of staff morale. However, when moving to study job satisfaction in variations of hospital settings, further differences emerge. Happell, Martin and Pinikahana (2003) in their comparative study of job satisfaction between forensic and mainstream inpatient care identify that there are higher levels of satisfied workers within forensic specialist settings. It appears from evidence of these two studies that mainstream inpatient

care is a prime site for low level satisfaction and morale. However, location or work environment are not the only factors associated with the apparent progressive disenchantment of staff. Low pay, quality of work environment, shift patterns, grading in relation to duties, unpaid overtime and extended working, according to Shields and Ward (2001), are all realistic aspects to address in order to improve occupational experiences of staff.

Yet, influences of organisational governance and media representations of mental health work can make pivotal contributions to the occupational experiences of staff working in this field and vitally, the ability to maintain a buoyant workforce.

Psychiatric Care and Public Relations; Nursing Culture in the Spotlight

During the last twenty years, a public insight into the working lives and practices of mental health nursing staff has been provided by both the media and parliamentary policy. These representations of more contemporary work practices of mental health staff have not been positive ones, with two particular incidences gaining much media and public interest; the Ashworth Special Hospital crisis, and the death of service user David ‘Rocky’ Bennett. Both incidents have illustrated the failings of psychiatric services, and more importantly the behaviour of nursing staff at the forefront of care provision. As will be illustrated within the descriptions of the two cases, attention towards critical localised incidents and events have had wider implications for the public relations of mental health services and psychiatric nursing as a profession.

Ashworth Special Hospital, amongst the other two Special Hospitals for England and Wales, Broadmoor and Rampton, operates under Section 4 of the NHS Act (1977) to maintain adequate security of patients requiring psychiatric treatment who have committed serious crimes or are at significant risk of committing a crime. Admission, leave and discharge to Special Hospitals is

restricted by the decision of the Home Secretary, and for many patients residing within these facilities, the prominent diagnosis of many is psychopathic disorder. Staff working within the Special Hospitals were once constructed of a coalition of nursing and prison officers, now treatment of those requiring a maximum security environment is administered by nursing and allied staff. However, what continues to exist is staff affiliation into not only nursing trade unions, but also the Prison Officers Association (POA).

According to Richman and Mercer (2000), the culture climate of Ashworth hospital up until the early 1990s was one which emphasised custody rather than care and treatment, and that attempts to change this approach were resisted through the influence of the POA. Significant problems with the nature of managing dangerous patients were becoming increasingly apparent, and the focus upon the level of danger presented by the client was put above all other care issues, leading to an anti-therapeutic custody-control centred regime (Willmott, 2002).

Matters culminated in a response to a Channel Four *Cutting-Edge* documentary. This documentary, presented the accounts of former patients and carers with allegations of inappropriate treatment of patients by nursing staff. Draconian work practices, over use and inappropriate use of seclusion and strict controlling regimes reflected a nursing culture more concerned with locking up dangerous people rather than providing care and treatment for individuals suffering with mental disorder. Public, agency and governmental interest into these allegations initiated the *Report of the Committee of Inquiry into Complaints about Ashworth Hospital* chaired by Louis Blom-Cooper Q.C.

In April 1991, the Blom-Cooper inquiry sought to unveil the key overarching problems regarding care and control within Ashworth Hospital. The final report, published in 1992 presented ninety recommendations to address the anti-therapeutic regime of the hospital. These recommendations were, and widely believed to hold, a positive future for Ashworth Hospital through a deliberate attack on old work norms and values and the 'formulation of a new hospital

culture' (Richman and Mercer, 2000, p.628). The Blom-Cooper Report (1992) recommended a total overhaul of services and organisational and staff attitudes. The far-reaching resonance of this report, the Special Hospital Service Authority (SHSA) Task Force and the increasing public attention facilitated by the media all provided the impetus for change. In light of this, the POA found it increasingly difficult to resist such pressures to improve the therapeutic environment.

In the months following this, services at Ashworth were turned around, with significant changes in leadership both at strategic and ward level. The interventions of the SHSA Task Force were most notable by the division of services at the hospital. Facilities and services were separated into units for mental illness (x2), special needs (x1) and personality disorder (x1) in attempts to manage diagnosis such as psychopathic or personality disorder collectively for improved supervision within a therapeutic environment.

The hospital, management, leadership and the image of nursing within Ashworth were further brought into question in a review of services within the newly formed Personality Disorder Unit (PDU), that the Blom-Cooper Report (1992) recommended. The Fallon inquiry, commenced in 1997 with the final report published in 1999, investigated the extent to which recommendations made by Blom-Copper (1992) were effective, and was also in response to staff feedback and new public concern over the liberal approach towards dangerous patients in therapeutic custody. As Willmott (2002) describes, the trigger for the Fallon inquiry emerged from a dossier of events and incidents on Lawrence ward (PDU) that had been compiled by a patient. The Fallon Report (1999) found that patients within the PDU services were effectively running the wards characterised by sophisticated crimes being committed such as financial fraud, identity changes, drug taking, alcohol consumption and organised pornography (including child pornography) rings. Unsupervised multiple visits to patients by young children has also occurred despite the wards being populated by paedophiles, rapists and murders.

Fallon (1999) concluded that the intentions of the Blom-Cooper Report (1992) to reassert the balance of custody and care had been introduced at too swift a pace, and now staff were in a situation whereby their authority had become diluted in a highly liberal PDU regime. For Fallon (1999), this report signified yet another critical problem in a long line for Ashworth Hospital. The functioning and operations at strategic and ward levels has had limited achievement and Fallon (1999) saw little potential for management to achieve success in Ashworth, not least due to its history of problems. Within his report, Fallon (1999) recommended that Ashworth Hospital be closed, however, Health Secretary Frank Dobson rejected this recommendation and Ashworth remains open today.

Inquiries and reports into therapy and security at Ashworth Hospital have impacted upon nursing staff greatly. The image of psychiatric nursing has undoubtedly become damaged, and been illustrated in the history of Ashworth, staff can often become confused about their role-set and how best to do their job. In addition, nurses and allied workers are often agents of political experimentation and instruction, and in cases through no fault of their own, become victim of negative images in the public imagination of 'not doing their job correctly'.

It may be seen that mental health nursing as an occupation has received the largest share of public and political criticism than any other nursing discipline. In addition to concerns at Ashworth Hospital in the 1990s, the David 'Rocky' Bennett case emerged as an example of so-called 'institutional racism' towards minority ethnic patient groups (Blofeld, 2003).

David 'Rocky' Bennett, a black thirty-eight year old patient being treated for schizophrenia in a medium secure unit in Norwich, died after being restrained by nursing staff for twenty-eight minutes. The restraint had being initiated following Bennett punching a member of nursing staff in the belief that he was being racially victimised. Four members of nursing staff restrained Bennett in the prone position on the floor in what Blofeld (2003) claimed as 'being

restrained with unacceptable force'. In addition, the methods adopted in restraining Bennett were not correct procedures in line with operational policy. The report into Bennett's death also highlighted that he had been given medication by nursing staff which had not been authorised by a psychiatrist or member of the medical team.

Managers and nursing staff were criticised within the Blofeld Report (2003) and it outlined that minority ethnic groups were in no way receiving adequate treatment or services which they were entitled to, this being attributed to attitudes of 'institutional racism' within the NHS. The evidence presented in the Blofeld Report (2003) was hard-hitting and as Esmail (2004) suggests, gained momentum in the wake of rhetoric of the Stephen Lawrence Inquiry⁵, which had labelled the police as 'institutionally racist'.

January 2005 saw the publication of the Department of Health document *Delivering Race Equality in Mental Health Care*. This document, some eight years following the death of David 'Rocky' Bennett provided mental health service providers with a comprehensive framework of delivering equitable care. At the launch of this policy, Health Minister Rosie Winterton remarked:

There are significant and unacceptable inequalities in access to mental health services that black and ethnic minority patients have, in their experience of those services, and in the outcome of those services.

(Winterton, 2005 cited in Kmietowicz, 2005, p.113)

Such inequalities and policy responses to their realisation represent deliberate attempts to challenge normative structures of work and practice. Work habits and the way in which agencies interact with the public are of considerable concern for all involved in service delivery and examples such as these highlight where improvements must be made. However, as some occupational practices take place more discreetly (for example, informal value structures amongst

⁵ McPherson Report (1999) considered the Police as institutionally racist as a result of no conviction of suspected murderers of black youth Stephen Lawrence. The McPherson report concluded that the failings in the police investigation would not have occurred had the victim been white, and that the police were not providing adequate services for black and minority groups.

employee groups), challenges to monitor service delivery are substantially more complex than just implementing a policy document.

Part Two: The Local Context

I think that the pace of change never used to be so apparent. There have been so many changes and teams have been separated and they have been forced to reformulate and restructure. There has been a lot of adaptation going on and staff have had to be flexible to meet all the changes in recent times.

(Staff Nurse Thomas; Humber Acute Ward)

This section provides key information on the organisational backdrop of the research site and the context by which these narratives of mental health work are situated. Staff Nurse Thomas' statement above highlights the importance of what follows in this section. Importantly, this overview details some of the organisational structures and bureaucratic influences active at the time of preparing this thesis, as it can be assumed with a high level of certainty, that some, if not all, may be subject to significant change over time.

A discussion of the nature of the five wards, Occupational Therapy department and community-based Crisis Resolution Home Treatment Team (CRHT) that operate within Hollybrook hospital will be provided within this section, with particular focus upon organisational imperatives of each department and improvement initiatives being carried out at this time. A salient issue which this section presents is to examine to what extent the nature of the wards are influenced by external decisions and the impact of changes in the economic statutory health service market.

This section has been constructed using the narratives and conversations provided by the employees who chose to participate in this study. Their discussions with the researcher have provided an illumination of the multifaceted practical daily encounters which they experience.

Service Modernisation

Hollybrook hospital was opened in April 2005. Purpose built facilities replaced accommodation within a traditional Victorian asylum building, located on the outskirts of a northern city. The new premises are within the vicinity of the now empty and derelict buildings of the old asylum. Those buildings still habitable are utilised as offices and recreational areas for service users.

Planning and construction of the new build took over ten years at a cost of over £14million. Moves towards new purpose built accommodation for mental health service users has been an ongoing strategy developed from Department of Health modernisation schemes introduced in the late 1990s (for example, the NHS Executive's document *Modernising mental health services safe, sound and supportive*, 1998).

Architecturally, Hollybrook hospital incorporates single bedroom accommodation in contrast to the dormitory living of the old hospital. Wards are divided between two floors and enclosed outdoor patio areas provide outdoor space for clients to use. Keys are a less dominant feature of the new Hollybrook hospital. They have been replaced by electronic fob entry systems which allocated staff can manage levels of accessibility and movement around the hospital. Closed circuit television is located in communal entrances and corridors of the main building and some garden areas are fenced and enclosed to a twelve-foot height. A café and shop are located on the ground floor used by staff and service users. In close proximity to the main hospital building is a gymnasium and further recreational areas for service users and workers.

In the time since Hollybrook hospital has opened, several changes have been made. Initially three acute admission wards were operating, but this was decreased to two within eighteen months of opening. Following this, Trent intensive rehabilitation unit opened in a ground floor ward which was occupied by Hayle older persons' ward. Hayle then moved to a first floor ward. The

functional (those over the age of 65yrs suffering with conditions such as schizophrenia, depression, etc..) older persons' ward was closed and service users allocated to Thames acute admission ward. The remaining empty ward is due to be occupied by an adolescent service.

Financial Buoyancy in a Sea of Change

The NHS Trust that this research has been conducted within, at this time, is undergoing significant changes to the services that it provides to the public. The most visible and highly emotive subject for participants has been the current financial climate that statutory health providers have found themselves within. The nature and functioning of wards, teams and departments is undoubtedly dependant upon spending within specific areas of the Trust.

The research site explored here is classed as a 'provider' Trust. Provider Trusts are those which provide services to the local health economy, and services are bought and paid for by Primary Care Trust (PCT) commissioners. In simpler terms, and in the case of in-patient hospital beds, the local Primary Care Trust (PCT) will commission (pay for) a certain number of beds per year from the 'provider' Trust. Spending on types and size of services is dependant upon the demographics of the local health economy, however, in recent years; the amount of funding being spent by Primary Care Trust (PCT) commissioners has decreased and mandatory savings have been imposed.

The ongoing cost improvement programme (CIP) occurring at the Hollybrook hospital is not unique to the geographical area, but representative of much wider initiatives undertaken by Primary Care Trusts (PCTs) nationally. At Hollybrook hospital, and as part of the cost improvement plan imposed on the provider Trust, additional plans and measures of cash releasing efficiency savings (CRES) are disseminated annually. In a bid to provide high quality care as efficiently as possible; the cash releasing efficiency saving (CRES) was set at circa £5.5million for 2009/10. In previous years, circa £2.5million cash

releasing efficiency savings (CRES) have been set. Meeting these savings targets is challenging for the planning of service provision and allocation of resources (for example, staff). According to participants, in general terms, the resemblance of services today to those of a decade ago are minimal.

We heard that there had been massive overspends by the Primary Care Trust, and due to this they wouldn't be able to buy any beds from us in the usual way which they once had. Therefore a huge cost-cutting exercise occurred, which seemed to focus on inpatient resources the most. Some staff thought that the place had become a lot more strenuous at times due to the lack of resources and money.

(Technical Instructor Pervis; Avon Occupational Therapy Service)

Since the introduction of cost improvement programmes (CIP) and cash releasing efficiency savings (CRES), Hollybrook hospital in particular has witnessed several changes to the services provided. Within the last four years, two wards have closed (one acute admission ward and one functional older peoples' ward) and one has re-opened as an intensive rehabilitation environment. The remaining ward was opened in 2010 as a speciality service for adolescents. To date, it appears that cash releasing efficiency savings (CRES) have been focused primarily upon inpatient service provision, though it is unlikely that this will remain the case as all services are undergoing reviews of their efficiency and spending.

Since 2007, the NHS Trust that Hollybrook hospital operates within has been a NHS Foundation Trust. Foundation Trust status is awarded to NHS Trusts following significant preparation and strategic planning, with an aim to become devolved from central-government (Department of Health) regulation. In doing so, NHS Foundation Trusts have the autonomy to make strategic and financial decisions on a local basis for the purpose of being more responsive to the needs of their local community (Department of Health, 2008⁶). One key aspect to the

⁶ The NHS in England: The operating framework for 2009/10

attainment of Foundation Trust status is that the Trust can keep its financial surplus and re-invest that in services.

Financial surplus is perhaps gained in the main via the sale of specialised services to other NHS Trusts. The development of specialised services which meet with evidence based decision making may well be a lucrative market for Foundation Trusts to enter into. Some specialist services may include; low secure environments, intensive rehabilitation services, specialist adolescent services (for example inpatient therapy units), eating disorder services, and psychiatric intensive care (PICU) beds. Services may be 'sold' to other NHS Trusts to provide an income, yet competition may arise, especially where competing or similar services exist within one particular geographic area. Concerns over the longevity of these 'saleable' services are raised by particular participants in this study and are discussed in subsequent chapters.

Foundation Trust status, coupled with cost improvement programmes (CIPs) have left some participants to this study nervous. Of particular concern is redeployment and prospects of redundancy. Additionally, some illuminate upon the problems that they face in maintaining some level of speciality or attachment to their work when the prospect of being redeployed is present.

Thirdly, workers face the influence of external forces (for example, politicians, policy writers, commissioners) in the structure of their work. For many, they are at the sharp end of political experiment, and they must work accordingly within frameworks of disseminated best practice. In mental health care, these are perhaps most evident in the recent introduction of multidisciplinary; Assertive Outreach Teams (AOTs), Early Intervention Teams (EITs) and Crisis Resolution Home Treatment Teams (CRHTs). These developments in community mental health care have occurred within the space of ten years and complement existing Community Mental Health Teams (CMHTs). The NHS Plan (2000) supported the national provision of such services as research evidenced supported the notion that mental health recovery could be best achieved within the community (or home) environment, rather than the potential

deleterious psycho-social effects of hospital admission. Supporting early discharge, engaging with difficult-to-manage client groups and intensive community supervision/support are key areas that these teams are mandated with. As a consequence, and particularly with the development of Crisis Resolution Home Treatment Teams (CRHT), admissions to acute admission beds have decreased and the length of time a service user is admitted to hospital has reduced.

Whilst this undoubtedly is beneficial for the recovery of the service user, the efficiency of community based teams has, according to the narratives of mental health workers presented later, impacted upon inpatient mental health working. For those working in the acute admission environment, the ward is characterised by acutely unwell individuals, rather than a balance of acute and recovering service users. Inpatient staff find themselves 'fire-fighting' situations and many complain of not feeling rewarded by witnessing the gradual recovery of service users that they once did.

The Acute Care Model (ACM), Accreditation for Inpatient Mental Health Services (A.I.M.S.) & Star Wards

During the period that this study was conducted, three major clinical frameworks/initiatives have been introduced, directly influencing and changing ways of working within in-patient and community services; The Acute Care Model (ACM), Accreditation for Inpatient Mental Health Services (A.I.M.S.) and Star Wards.

It is perhaps one of the most difficult balances that healthcare staff must undertake; melding into practice equal parts of attention towards professional and bureaucratic responsibilities, and the humanistic and altruistic aspects of the caring profession. Recently, initiatives such as Star Wards have provided benchmarks for professionals to aim towards that fully recognise flaws in practice in the areas of service user experience. Formalising the evaluation of

more informal practices has gone a significant way in improving services for service users. However, the implications for nursing and allied workers who have to juggle these multi-dimensional approaches to their work will be broad and complex.

The Acute Care Model (ACM)

During 2008/09 a model for the treatment process for acute adult admissions was introduced across two hospitals within this Trust. Whilst there is little research evidence of the efficacy of this model (but see, Johnstone and Zolese (1999) for indications of the problem⁷), the model has been adopted and reports to have made significant impact in its short period of implementation. The main foci of the Acute Care Model (ACM) are reducing the number of hospital admissions, preventing relapse and re-admission and improved continuity between in-patient services and Crisis Resolution Home Treatment Teams (CRHT). These objectives are primarily met by an overall improvement to consistency in approaches to acute adult admissions.

Under the Acute Care Model (ACM), a single Consultant Psychiatrist will undertake the role of responsible medical officer (RMO) for all in-patient adult admissions. Care is reviewed on a daily basis with the multidisciplinary team (CRHT, ward staff, occupational therapists) to facilitate actions required for individual care plans. In previous models, service users were allocated a consultant psychiatrist based upon the locality of their general practitioner (G.P.). Several consultant psychiatrists would have responsibility for several geographic areas. The problems which this model presented were that upward of eight consultant psychiatrists would visit the ward during the week for a ward round with their service users. This put increased pressure on ward staff, and communications with community teams and Crisis Resolution Home Treatment Teams (CRHT) can become inconsistent at times.

⁷ See, Johnstone, P. and Zolese, G. (1999) 'Systematic review of the effectiveness of planned short hospital stays for mental health care'. *British Medical Journal*. 318, pp1387-1390

Whilst the Acute Care Model (ACM) is in its infancy at the research site, overall consensus by the multidisciplinary team reporting in this study, is that efficiency and communication has been greatly improved, with a more structured and coherent framework for care planning of adult admissions.

Accreditation for Inpatient Mental Health Services (AIMS)

The Healthcare Commission's report 'Standards for Better Health' (2004) outlines key standards necessary for healthcare service providers. The Royal College of Psychiatrists (RCPsych) has invited mental health care providers to apply to become accredited if they meet key areas of care provision. AIMS is met by achieving standards in five main areas; (i) General Standards, (ii) Timely and Purposeful Admission, (iii) Safety, (iv) Environment, and (v) Facilities and Therapies and Activities. Within each standard a three tier assessment of achievement is used;

- **Type 1:** failure to meet these standards would result in a significant threat to patient safety, rights or dignity and/or would breach the law;
- **Type 2:** standards that an accredited ward would be expected to meet;
- **Type 3:** standards that an excellent ward should meet or standards that are not the direct responsibility of the ward.

The accreditation process is completed via the use of self review and peer review from an external team. Data is collected in several ways including questionnaires for staff, service users and carers. Observational visits of AIMS representatives are arranged as an aspect of the peer review phase of accreditation. The AIMS Accreditation Advisory Committee will recommend their decision for accreditation based upon data that has been collected and accreditation will be made on the following levels:

- **Category 1:** accredited with excellence.
- **Category 2:** accredited.

- **Category 3:** accreditation deferred.

The level of accreditation awarded is dependent upon the number of ‘type 1; 2; or 3’ achievements that are met. AIMS initially focused upon adult admission wards, but have recently been rolled-out to older peoples’ wards and also PICUs.

Star Wards

The Star Wards framework holds many underlying similarities with the AIMS projects. Both are concerned with evaluating and making changes to in-patient wards in order to improve the service user experience and to meet and exceed expectations of the main stakeholders (for example, service users and carers).

Star Wards aims to provide a networking of good practice amongst mental health Trusts nationally in order to provide advice and guidance from professionals, service users and carers on several areas of the in-patient experience. A great deal of focus is placed upon the allocation and use of time during a service users’ stay in hospital. Seventy five action points are recommended within the Star Wards programme, ranging from structuring social activities (for example, board games, quizzes) to service user involvement in how the ward is run on a daily basis. Several changes have been made within the wards at the research site, based upon recommendations of Star Wards. ‘Protected therapeutic time’ has been allocated where nursing staff can liaise with their service user caseload without the disruption of visiting multidisciplinary staff. Activity co-ordinators have been allocated amongst nursing staff to ensure that daily ward community groups/meetings are maintained and activities planned in collaboration with the wishes of service users.

The emphasis of Star Wards on customer service and satisfaction provides nursing and allied staff with somewhat of a paradox in terms of the nature of public sector mental health work. Star Wards stimulates the need for equal

attention to be paid to the experiences of those using services rather than an over bearing focus upon its more formal counter-part, bureaucracy and paperwork.

The Evolution of the Crisis Resolution Home Treatment Team (CRHT)

The adoption of a framework of crisis working at the research location commenced in 2004. Crisis Resolution Home Treatment Teams (CRHT) main aim is to reduce institutionalisation of mental illness sufferers, thus eliminating some of the harmful⁸ effects of hospital admission. Crisis working also was seen to efficiently deliver what community mental health teams (CMHTs) were already doing to some extent. For many community mental health teams, crisis working was intrinsic to their role, however, limitations on time and workload often meant that this was not met to its full potential (Smyth, 2003). Crisis resolution home treatments teams (CRHT) were therefore implemented to support the ongoing work of community mental health teams (CMHTs), facilitate early discharges from hospital through in-reach, assess and home treat those deemed as appropriate for the remit of the service, and gate-keep hospital beds by offering alternatives to hospital admission.

The nature of assertive crisis work is demanding, and the team at the research site is diverse in experience and occupational speciality. Within the team there are generic community specialist practitioner posts (for which nurses, occupational therapists, and social workers may apply), occupational therapist(s) and clinical support workers. This multidisciplinary approach allows for a variety of expertise to be applied in the assessment and home treatment of service users.

The Crisis Resolution Home Treatment Team is based in the grounds of Hollybrook hospital. Those who have worked within the team since it was evolved were a mixture of new applicants and redeployment from services that

⁸ For example, social stigmatisation correlated to hospital admission.

were terminated, such as day hospitals and community rehabilitation. Those members of staff who have joined since have applied for jobs in the usual application/interview manner or have been seconded. The team is made up of two band seven lead practitioners, fourteen band six specialist community practitioners and five band three community clinical support workers.

Daily work involves four shifts per-week, either 08.00-18.00 or 12.00–22.00 for a full-time worker. A rolling rota of on-calls equates to approximately one on-call per week for each full-time band six specialist community practitioners. On-call duty follows a 12.00- 22.00 shift until 08.00 the next morning. If called, specialist community practitioners attend the local accident and emergency department to assess any service users referred by the duty doctor or accident and emergency staff. At night, as during the day, it is the responsibility of the specialist community practitioners to identify whether hospital admission is indicated and if not, to offer home treatment as an alternative, or referral to community mental health teams or primary care trust (PCT) primary mental health services. In cases where hospital admission is indicated, specialist community practitioners act in a bed management capacity to direct the service user to the appropriate resources.

During normal daylight hours, specialist community practitioners will in-reach into hospital wards to offer supported early discharges, attend daily care planning meetings, deliver home treatment and assess presenting mental health related cases. On a daily basis specialist community practitioners will work and liaise with a number of outside agencies such as social services, private care providers, other hospitals and the police. On occasions specialist community practitioners are required to assess prisoners at the local police station.

In-patient mental health services

The research site is a local mental health unit catering for the needs of diverse rural and inner-city areas. It provides two acute admission wards, one

Psychiatric Intensive Care Unit (PICU), one older peoples' ward for organic mental illnesses, and one intensive rehabilitation unit. The hospital runs a twenty-four hour shift system, with day duty commencing at 08.00 and finishing at 20.00hrs. Night shift commences at 19.45 and finishes at 08.10hrs. For a comprehensive overview of these wards, please refer to *appendix ix*

The Patient Landscape

The introduction of the Crisis Resolution Home Treatment Team (CRHT) and the Acute Care Model (ACM) has significantly altered the 'type' of service users that in-patient services come into contact with.

For many years, staff report that acute admission wards were an eclectic mix of acute and chronic service users, new admissions and delayed discharges. Acute working now involves the management on a daily basis of a concentration of acutely disturbed individuals occupying close proximity on the wards. Where once the acutely unwell were distributed across three admission wards and several PICUs, these service users now occupy two admission wards with access to a limited number of beds on a PICU. In addition, those working on adult admission wards express that their expertise has become somewhat stretched as a consequence of adults over 65yrs being integrated on the adult wards.

As a profession, psychiatry is constantly widening its expertise, but in doing so, the range of diagnosis is expanding. Personality traits are now much further assimilated into psychiatric diagnosis, not least reflected in the Mental Health Act (2007). The outcome from this is a patient population with a wide variety of symptoms and conditions considered as treatable. Older staff report that the clientele today is dramatically different from the service user demographic of years gone by, presenting more and more complex conditions and requiring more and more complex care management.

‘Traditional’ diagnosis such as schizophrenia, bi-polar disorder and depression are seen as somewhat legitimate diagnosis for hospitalisation by ward-based staff. Dual diagnosis (for example, alcohol or illicit drug associated problems), along with personality disorders are seen to present a certain number of challenges for staff in terms of managing care and possible disruption to the ward milieu.

Chapter Summary

Part one of this chapter has provided examples that give some insight into how public relations between mental health nursing and those outside of the occupation can become strained. Media portrayal of critical incidents may well amplify public opinions (for example, endemic bullying and mistreatment) of an occupation such as psychiatric nursing. However, incidents which are focused upon are often only snap-shots and are in no way endemic across a whole discipline. Such media populism that highlights organisational and professional controversies can be damaging to the profession as a whole, not least in projecting images of professionalism and benevolence.

However, political decision making and policy reform is often in response to public anxiety or localised incidents and yet present challenges to mental health workers in their daily duties. The constant dilemma of ‘how best to do the job’ is set against the changing landscape of instructions of ‘how to do the job’. In the ambitious process of ‘saving face’ between daily duties in challenging environments, political and policy instruction, and public opinion the mental health worker is undoubtedly torn within their individual role-set.

Part two of this chapter has provided a contextual overview of the research site and the services that are offered to the local community which it serves. In addition, a background has been provided on the economic situation this, and many other NHS Trusts face. Furthermore, attention in the future is highly likely to be paid to the development of systems of financial saving, not least in

the attempts by the Coalition Government to address the national financial deficit.

Current programmes that address issues of care quality have also been outlined within this chapter. Target and goal setting, particularly in the areas of the ‘service user experience’ are evidence of commitments, both nationally and locally, to the improved standards of care that are conveyed to the public. Obligations rest not only at a strategic or managerial level, but importantly quality standards can only be met with the cooperation of the shop-floor staff that delivers these services. Delivery at the forefront of clinical services is the ongoing focus of this study and chapters later in this thesis present the main findings of the study.

Chapters 2 and 3 examine some of the theoretical and conceptual dimensions that have emerged from previous research within occupations sharing similar characteristics in a bid to begin to understand the complexity of the contemporary occupational role-sets.

CHAPTER 2

THEORISING MENTAL HEALTH WORK

While there is very little analysis of the culture and working practices of mental health workers, this chapter introduces the main theoretical concepts inextricably related to the sociology of occupations. In light of the dearth of literature specific to the social exploration of mental health work, chapters two and three places a great deal of focus upon studies already completed in the areas of prison work and policing. In doing so it aims to set the thesis in context, addressing issues of emotional labouring, occupational cultures, working personalities, total institutions and institutional working and the key dichotomy of care *versus* control

This chapter delivers key theoretical discussions of the uniqueness of institutional working, drawing heavily from Goffman's (2007⁹) theory of the 'total institution'. Within this chapter the dichotomy of care versus control and discipline versus dependency is discussed with specific reference to the pendulum swing action of political and policy measures. The staff characteristics which are influenced by the work environment are discussed, highlighting the stress and emotional labour involved in an environment where there is the need to be authoritative and caring, but also in an environment where a daily risk of violence exists. Section one concludes by addressing some structural components of the institutional work environment such as hierarchy and managerialism.

Throughout this thesis, the focus remains on the tenuous balance of care and control which nursing and allied staff must manage. The degree to which the scale slides between the ideological-opposed differences of care and control is rarely a process which is contributed by one single issue or action. Often, the

⁹ Erving Goffman's text *Asylums* was first published in 1961. This text has been subsequently reprinted several times, the latest version being that in 2007

swing of the metaphoric pendulum is dependant upon complex policy influences (for example, growth and influence of actuarial practices) and political agendas. Contemporarily and historically, the movement of the pendulum had been seen to swing from one extreme to another not least notable from periods of large scale confinement during the Eighteenth, Nineteenth and early Twentieth century, to the process of de-institutionalisation and closing of county Asylums during the late Twentieth century. However, caution should be raised that the pendulum swing between two opposing philosophies may well be an over simplistic representation of an extremely complex problem. Dealing with this constantly changing situation demands a lot from staff who have to deal with the issues surrounding this dichotomy on a daily basis. Workers located within mental health environments are faced with a collection of evolving and changing conceptual and practical problems associated with carrying out their job role. In this situation, nursing and care staff are exposed to the pressures of politically expedient policies of care and control (Smith, King, Bradshaw and Willmott, 2000) in addition to the problematic nature of nursing a significantly diverse client group.

The dilemmas surrounding the twin imperatives of therapy and security are manifested within the normative structure of daily work for nursing and allied staff (for example, social relations with patients, the physical environment they work within and the policy and legislation which guides their practice). Yet, for workers there is a continuous expectation to carry out their job in an effective and efficient manner despite the social, emotional and psychological pressures that they may experience, and not least affecting the degree to which mental health work impacts upon an employee's outlook on their world.

Legislative Reform and the Swing of the Care-Control Pendulum

The rise of institutionalisation in the seventeenth century marked a 'significant shift in patterns of social control' (Seddon, 2007, p.20). What is remarked by

Foucault (2001) as a period of 'Great Confinement' was, in Foucault's (2001) opinion and retrospective observation, a large-scale importing of individuals from county workhouses and the communities into asylums for the insane. The populating of the 'mad houses' during this time signified the diverse inclusion criteria and definitions of what was objectively referred to as conditions of madness or insanity. Often those taken and indoctrinated into the asylum were merely objects to attempt to enrich the theories of an emerging psychiatric discipline, or those who posed a threat to the economic and social growth of the bourgeoisie.

The large county asylums soon became symbolic physical structures of warehousing the poor, under-privileged, and socially deviant and at times mad groups of society. The detention of which was authorised by those members considered as powerful or of privileged class, and their duty was to maintain social stability and order through large scale exercises of control. The growth further continued, and through recommendations and responsibilities to provide care of the 'mad' determined in the Lunacy Act (1845), building work commenced on the extension and commissioning of new county asylums. 'Victorian Asylumdom' (Foucault, 2001; Scull, 1979; 1993) marked a significant milestone in psychiatric medicine at a time of segregating the insane in a centralised and unitary manner away from the rest of the community (Morrall and Hazelton, 2000).

The increasing momentum of the asylum as a social symbol and the medicalisation of madness (Illich, 1977; Scull, 1979; 1993) which evolved where professional role definition (for example, doctors and nurses) took place aided the legitimacy and need to 'care' for those housed within the asylum (Rogers and Pilgrim, 2006). The cascading of power from bourgeoisie to psychiatrist to nurse to attendant not only expanded the number of agents of social control but also, as Morrall and Hazelton (2000) discuss, through the expanding dynamics of psychiatry as an occupational discipline, a capitalising of market opportunity took place where the profile of psychiatric medicine was viewed as an important and credible discipline.

Diversification of professional roles commenced during the mid-twentieth century. Community psychiatry was heralded to be an answer to problems raised by research academics such as Goffman (2007) and increasing economic stresses produced by a National Health Service in its infancy. Advocates for the 'open hospital' such as British mental hospital directors MacMillan and Rees, during the 1950s and 1960s compounded upon what Goffman (2007) had persuasively put forward; that the problems associated with mental patients were not wholly illness related but also influenced by the patient's surroundings, where the 'total institution performed a custodial function', and so impeded the recovery of mental patients (Scull, 1984, p.96). In 1954 the peak of psychiatric bed occupancy in England and Wales was witnessed, with 152,000 patients residing within city mental hospitals and county asylums (Johnson, Zinkler and Priebe, 2001, p.51). The 1960s onwards, both nationally and trans-Atlantically, saw a slow but progressive shift of psychiatric care to the community, with programmes or resettlement and decanting of asylums into a variation of community settings including private dwellings, residential units, shared living and bed and breakfasts. As the patient population moved, so too did the nursing workforce, with greater emphasis on community care culminating in the mid-to-late 1980's and 1990's with the National Health Service and Community Care Act (1990).

By this time, pharmacology and community based therapies and treatments were now readily available for psychiatrists and nursing professionals to administer and prescribe rather than them maintaining the role of 'glorified administrators of huge custodial warehouses' (Scull, 1984, p.79). Evidence was also suggestive of de-carceration of mental patients coinciding with developments in the types and administration of psychotropic medications. Depot injections¹⁰ and the lengthened half-lives of oral tablets meant that no longer was it necessary for all mental patients to be supervised taking medication at the hospital clinic door¹¹.

¹⁰ Slow release intra-muscular injections which are administered usually on weekly or bi-weekly basis, eliminating possible failures of oral medicine concordance.

¹¹ Traditionally, within the psychiatric hospital, patients would queue at the clinic door for medication dispensing at set times during the day.

but concordance with medication could take place and be monitored in the community.

This is not to say that community care was ideal, on the contrary, it has been subject of much criticism. Foremost, the argument emerged as to whether asylum or hospital based care was actually the most appropriate place for many mental patients to stay as despite the socially damaging effects of the mental asylum, it provided a much more safe and secure place than the patient may experience in the community (Morrall and Hazelton, 2000). Secondly, the risk of isolation and social exclusion becomes heightened as labelled and stigmatised groups are integrated into the centre of communities, which as research has shown in some cases, necessitates disenfranchised groups to maintain their social relationships and structure within their designated group, with little evidence of integration into the wider society (Cambridge, *et al*, 2003). Under legislation, Community Supervision (Sec25 Mental Health Act 1983), Guardianship Orders (Mental Health Act, 1983) and Community Treatment Orders (Mental Health Act 2007) have also been fiercely criticised on grounds of human rights of mandatory supervision in the community. Researchers in this area purport that compulsory supervision in the client's residence is only assisting in higher levels of exclusion from social peers and neighbours and limiting the level of social inclusion the community practitioner can offer due to levels of control and background disempowerment and segregation (Bertram and Stickley, 2005). The failings in community mental healthcare have not exclusively emerged from policy debate or academic investigations, but also compounded by the then Health secretary, Frank Dobson. 'Too many vulnerable patients were being left to cope on their own, creating a danger to themselves and the public' (Dobson, 1998).

However, in the wake of such a statement, as Johnson *et al* (2001) put forward, policy discussion following this concluded that there was need for some expansion in secure beds, but no fixed plans to commence large-scale re-institutionalisation. Yet, rising public anxiety of media representations of a small number of mentally disturbed offenders in the community (for example,

the murder of Jonathan Zito (1992), savage attack upon Lynne and Megan Russell (1997), attempted murder of his GP by Matthew Richards (2001)) 'highlighted violent tendencies of a minority of the most seriously mentally distressed, increasing the visibility of what Foucault described as 'unreason'' (Morrall and Hazelton, 2000, p.92). The public safety debate had once again been reopened, and the effective management of dangerous individuals with symptoms of mental disorder has been brought into question.

The shift in political thinking and a re-emphasis on public protection was illustrated with a plan to reform Mental Health Act law and to ensure that those who were previously on the fringes of psychiatric diagnosis such as Michael Stone's diagnosis of Dangerous and Severe Personality Disorder¹², were not excluded from treatment under mental health legislation. Correction of this problem was tackled in several ways, not least by additional spending on community and inpatient services, but also by an overhaul of Mental Health Act legislation where two Mental Health Bills were rejected prior to a new Act receiving Royal assent on 19th July 2007. Such definitive legal developments in this area highlight critical changes in political and psychiatric discourses where a reformed and robust legislative structure has been developed. However, the nature and circumstances surrounding these changes have attracted significant critical attention for their extended powers.

Background changes have also been made, and once again the rhetoric of treatment turns to higher levels of control. The publication of *Personality Disorder, No Longer a Diagnosis of Exclusion* (Department of Health, 2003) brought about early inklings of how mental health services would be shaped in the future to accommodate those with personality disorder who had previously fallen through the treatment net in secondary services¹³.

¹² Michael Stone, an individual with history of antisocial personality disorder was found guilty of the murder of Lynne Russell and attempted murder of Megan Russell in 1997

¹³ Primary Services refers to provisions such as GP. Secondary services refer to hospital care or care which is referred on by GP or primary care team.

[In the draft Mental Health Bill] – the broad definition of mental disorder, the abolition of the so-called “treat-ability test” in relation to psychopathic disorder and the provisions enabling compulsory treatment in the community – will highlight the need for new community and in-patient services.

(Department of Health, 2003, p.5)

Additionally, the Ministry of Justice based on the governments Dangerous Severe Personality Disorder (DSPD) policy paper have invested in what have been regarded as *hybrid* prisons, specialised units for individuals presenting with symptoms associated with DSPD. Currently, programmes are in place at Broadmoor and Rampton Hospitals, Frankland and Whitemoor prisons where collaboration between the Home Office, Ministry of Justice, HM Prison Service and NHS assess and treat up to 300 individuals presenting with symptoms meeting with the DSPD assessment criteria.

Widening the net of diagnosis by removing previous ‘treatability tests’ and the broadened categories of mental disorder, the new Act also widens the criteria for legitimate detention. The Mental Health Act (amended) (2007) introduces criteria for detention that ‘appropriate medical treatment is available’, however, this may take many forms, for example, pharmacology or long-term residential interventions.

Attempts to rectify the mistakes encountered as a consequence of de-institutionalisation, reformed Mental Health Act law and the service provisions which it stipulates mark a return in a more limited form to re-carceration with the re-emphasis on in-patient care in a bid to maintain satisfactory levels of public safety and the use of law in changing behaviour (Prins, 1996; 2008). Moreover, taking new and innovative DSPD units as a comparative example, as Scull (1993) claims, the birth of the Asylum in the eighteenth century was a consequence of the State implementing centralised control measures. Although modern hospitals and secure units are not visually identical to asylums of the past, taking into account the re-introduction of control defined treatment discourses, this may well be the symbol of a new age of ‘Asylumdom’.

‘Care versus Control’ within the ‘Total Institution’

The nurse is subject to all the contradictions which conspire to frustrate the attempt to provide therapy within a more explicit remit of social control.

(Burrow, 1991a, p.23)

Sociologists have long been occupied with the influences of physical and spatial environments upon those experiencing it first-hand. Such analyses have pointed towards the potentially deleterious effects that the physical environment and social systems within impose upon those coming face to face or living through their regimes.

Erving Goffman’s seminal text *Asylums* (2007) documents the social situation of mental patients housed within asylums for the insane in the mid 20th century. Whilst uncovering the systems that strip the mental patient of their usual social arrangements and individuality, Goffman (2007) posits several theories of how this is done. One of the most significant themes is that of the ‘total institution’. A term broadly used to describe the physical and organisational characteristics which obstruct the mental patient’s usual social intercourse (Goffman, 2007). Goffman (2007) classifies different types of ‘total institution’ from homes for the blind and orphaned, to ships, monasteries and army barracks. For Goffman (2007), the mental hospital fits securely within the concept of ‘total institution’ for reasons which will be discussed further.

The social arrangements which psychiatric hospitalisation manipulates and influences are often opposed to those which the patient experienced before entering into patient status. Goffman (2007) describes that even the most basic arrangements such as sleeping, playing and working in different places is removed once entered into the hospital, and that the central feature of the ‘total institution’ breaks down the barriers which ordinarily separate these three spheres of life. Scheduling of events and batch living are seen to assist in the control and coercion of large groups with minimal numbers of staff or

supervision and thus enhancing the limitations of the patient's social mobility to the detriment of their sense of self.

For some years, the work of Goffman (2007) has been used to criticise inpatient care, not least being influential in political thinking surrounding de-institutionalisation and care in the community. Yet, it is only recently that researchers have begun to question to what extent Goffman's (2007) work is applicable to modern mental health inpatient services. Moreover, mental health services have undergone huge levels of modernisation and change as well as psychiatry perpetuating itself into the new millennia. This is not to say that institutions and institutionalisation have no negative effects which Goffman (2007) put forward, but rather that the *totality* of the inpatient climate is somewhat less restricting and open to negotiation through the nurses and workers employed in such areas.

In *Asylums* Goffman (2007) noted that many of the features of the 'total institution' were managed and maintained by the representatives of authority - the staff. It was the measures which staff insisted upon which took over the social responsibilities of the inmates and limited the influences from outside or 'normal' domestic life of the patients. Although Goffman (2007) did make the realisation that there was the possibility for the 'total institution' to be permeable, *Asylums* neglects to raise these in any detail and forms its discussion around the totality of the mental asylum.

Jones and Fowles (1984, p.12) state that 'no institution is completely closed or total', and that there is the possibility for the term 'total institution' to be used inappropriately. According to Goffman (2007), total institutions comprise of four main characteristics; batch living, binary management, the inmate role and the institutional perspective.

Batch living within an institution such as a mental hospital, for Goffman (2007), represented an observation of a situation whereby inmates or patients living within the immediate company of others, and an expectation for conformity in

daily actions. Jones and Fowles (1984, p.13) further explain that this situation is achieved by a 'bureaucratic type of management'. Scheduling of daily events, strict routines and enforcement of rules all characterise what is described as 'batch living'. Binary management refers to the separation of the cultural groups of staff and patients. Power and control are both salient issues in which a distance between the two groups is achieved. The inmate role consists of a process of what Goffman (2007) labels as 'disculturation' or 'role stripping'. Disculturation of inmates or patients was observed by Goffman (2007) as the process by which ordinary people who were admitted to hospital undertook a transformation into an inmate or patient social role. Goffman (2007) claims that the regimes and social processes of the 'total institution' inflict a new way of controlled life (or institutionalisation) upon the individual, and that there is little potential to revert back to normal functioning if discharged. Finally, Goffman (2007) describes the 'inmate perspective'. This is characterised by a loss of personal identity and succumbing to institutional rules imposed by staff and environment. Jones and Fowles (1984) illustrate how patients or inmates cope and utilise what Goffman (2007) describes as 'secondary adjustments'.

- (i) the inmate may withdraw, cutting himself off from contact.
- (ii) He/she may become intransigent and fight the system.
- (iii) He/she may, in a vivid phrase become colonised, paying lip service to the system.
- (iv) He/she may become converted, genuinely accepting the institutions' view of himself, and what is acceptable behaviour.

(Jones and Fowles, 1984, p.16)

Prior (1988) examined the extent of spatial organisation in psychiatric hospitals between 1973 and 1982. It has emerged that psychiatric discourses of care and control are entwined with the spatial arrangements of asylums or modern psychiatric care. Nineteenth and early twentieth century psychiatric discourses, were focused on the regulation and control of the body in a bid to protect the economy and those threatened by those without sanity (Morrall and Hazelton, 2000). A period of 'Great Confinement' (Foucault, 2001) of those who opposed the bourgeoisie led to the separation between sane and insane and in Foucault's

terms 'reason' and 'unreason'. Those labelled as the 'unreasonable' fell victim of segregation and a period of 'Victorian Asylumdom' (Scull, 1993). This segregation not only did so in the immediate physical environment of patients, but also through geographical location. Situating large centralised county asylums on the fringes of the city or community was symbolic of segregating the asylums inhabitants from the wider social groups, enhancing the state of difference between those in mainstream society and those deemed in need of confinement.

Psychiatric medical discourse took a dramatic shift during the 1980s¹⁴ and was strengthened by legislation in the National Health Service and Community Care Act (1990) and the introduction of a number of policy measures and initiatives to reduce hospital beds and move mental health care to the community setting. A programme of building new hospital facilities commenced during the 1990s and up until the present day, with cash injections from central agency to support an anti-stigmatisation campaign. In addition, as Prior (1988) discusses, the rehabilitation and recovery discourse was strengthened by the symbolic meaning behind the location of new hospitals and style of building. Ramon (1985) considers how the medical knowledge of psychiatry and general medicine are amalgamating over time and the inter-reliance upon one another through common goals and bonds. The building of new psychiatric facilities in close proximity of general healthcare is a significant representation of this bond and goes some way to reintegrating the hospitalised psychiatric patient into society. Furthermore, Prior (1988) talks of the progression away from asylum and sanatorium internal architecture, fixtures and fittings are updated to resemble hotel style or homely facilities and not the decoration and interior which echo the old county asylum.

Prior's (1988) example has highlighted the inter-relationships between medical discourse and spatial environment in terms of historical developments in

¹⁴ Building upon the momentum of Enoch Powell's 'Water Tower' speech in 1961 and the publication of the Hospital Plan (1962).

psychiatry, but socio-cultural organisation within spatially restricted environments goes further as is discussed in her concluding thoughts:

Space and spatial categorisations exist in their own history and they constrain and restrict, as well as reflect and constitute various forms of social activity. To comprehend that history and to understand those constraints they need, above all, to be analysed in terms of the human practice in which they are embedded.

(Prior, 1988, p.110)

Early functional theories of the social importance of space (and time) (for example, Durkheim and Mauss, 1903) have given way to numerous attempts to understanding the social and cultural artefacts which the built environment facilitates in producing and maintaining social organisation (King, 1980; Hiller and Hanson, 1984; Giddens, 1984, 1985; Prior, 1988). What has emerged is that spatial organisation within the built environment is integral to social and occupational life and, therefore, the building and structural form itself contributes to the distinct sets of values and ideologies which workers subscribe to within their sub-cultural groups (Trice, 1993). Consequently, maintenance of social organisation (and ultimately control), through the built environment, indicates that physical and spatial features uphold and reinforce the key organisational imperatives of mental health work (for example, locked doors, walled gardens, communal dining, seclusion rooms). In doing so, the very nature of hospitals, hospitalisation and the mechanisms by which they operate indicate that Goffman's (2007) concept of the 'total institution' remains a salient feature in the process of enforcing distinct sets of values, beliefs and social responses influenced by the spatial and built environment of in-patient care.

The configuring of space and ultimately the spatial categorisation that takes place is a representation of the socio-economic goals and values that the organisation regard as central to their philosophy (King, 1980). In the case of the psychiatric hospital or unit, this philosophy is the balance between care and control, providing treatment for illness and maintaining the safety and security of themselves and the public. This dichotomy which exists in attempting to deliver commensurate levels of care and control under one roof is both

important in adhering to policy direction and public protection, but also in providing an environment which is therapeutic and contributory to the effective treatment of mental disorder and rehabilitation of the service user. Getting this balance right is in part the worker's ability to interact appropriately in certain situations but also some aspects of this spatial environment is physical and rigid (for example, windows with removable handles, main doors which are locked, enclosed garden/recreational areas) and may contribute to an environment which appears as custodial rather than treatment orientated. The work experience of every worker is intimately affected by the qualities and organisation of the physical work environment (Baldry, 1999). The ideological values attached to a particular physical environment directly impact and influence those working within it. Moreover, the building itself, and all that associates itself with the physical characteristics (for example, furniture, security, location and layout) conveys and maintains this manifestation of culture (Lawrence and Low, 1990).

Goffman's (2007) theorising of the influence and impact of institutional care has further been considered in contemporary analyses of treatment environments. In a recent ethnography of acute inpatient care by Quirk, Lelliott, and Seale, (2006), the values of the 'total institution' are challenged and this research provides much relevance in its findings of the extent to which modern wards are permeable, and how the staff working in those areas are involved in managing the extent of ingress of external influence onto the ward.

Quirk *et al* (2006) articulated that no longer are all aspects of a patient's life performed on the hospital premises. Evidence is presented to suggest that there are many external factors of outside, domestic life which permeates what was once considered as a closed environment. Therefore in light of their findings, Quirk *et al* (2006) posit that 'institutional care should be regarded as degrees of permeability rather than degrees of totalitarianism' (Quirk *et al*, 2006, p.2114). In identifying what indicates greater degrees of permeability, Quirk *et al* (2006) recommend that the following are substantial evidence of a breakdown of institutional totality;

- (i) The comparatively short stay of psychiatric patients, questioning whether people remain in hospital long enough to experience the difficulties of the so called 'total institution'.
- (ii) The ease at which drugs and other illicit substances find their way onto wards e.g. regular visitors.
- (iii) Extension of nurses responsibilities beyond the boundaries of the wards spatial environment. For example, community nurses calling upon the knowledge of hospital nurses following discharge.

Quirk *et al* (2006)

Staff involvement in managing the extent of outside influence onto the ward is unveiled as multi-dimensional. Quirk *et al* (2006, p.2110-2113) look towards social distance between patient and worker being reduced in terms of; 'lack of uniform', 'broad reflections in staff of the patient population for example, in race, gender, age and social class' and 'use of staff forenames'. Physical management of permeability by staff was found to consist of; 'the use of discretion', 'levels of observation' and 'assessing the legitimacy of visitors'. It was also established that permeability was fluid and often was an outcome of negotiation between staff and patient, although in most cases staff were the only controllers of this permeability as they were entrusted with the 'tools that permit them to have more control than patients can'.

On the one hand, a move away from the destructive effects of the 'total institution' upon the identity of mental patients (Caudhill, 1958; Goffman, 2007) may be seen as a positive step. Yet, Quirk *et al* (2006) suggest that adverse effects of permutation of the ward such as drug use and clients absconding were also to the detriment of the patient population in terms of time taken up managing adverse events rather than patient contact.

Whilst Quirk *et al* (2006) present an insightful discussion on aspects of a decline in the nature of the 'total institution', and despite permeability being evident, it is questionable to what extent other factors contributing to a concept of a 'total institution' have diminished or become obsolete. Many aspects of life for both service users and workers within the mental health hospital remain controlled by the organisation or professional discipline. Workers and patients continue to be

subordinated to and dependent upon the authorities (Goffman, 2007) in many aspects of their daily routine and are subjected to institutional regimes (for example, administration of medication, access and egress to ward areas, therapeutic observation). Structural, environmental and organisational influences will assist in the shaping of behaviours, decision making and action of both staff and patients. In doing so, the repertoire of behaviours which are presented by both parties amount to degrees of either consensus or conflict with the institutional regime and the extent to which the multi-faceted elements of the 'total institution' impact upon the individual.

In reviewing research completed on patient behaviour in relation to changes in the hospital environment (see, Sommer and Ross, 1958; Holahan, 1974; Petersen, Knapp, Rosen and Pither, 1977; Melin and Götestam, 1981; Baldwin 1985) more positive patient attitudes and behaviours have been observed including greater levels of interaction. However, as Tyson, Lambert and Beattie (2002) put forward, the impact of physical change in the hospital environment is equally important as reviewing patient behaviour, as a patient's change in behaviour may well be a result of changes in staff behaviours. In studies of staff attitudes towards refurbishment and improvement of the hospital environment (see, for example, Stahler, Frazer and Rappaport, 1984; Whitehead, Polsky, Crookshank and Fik, 1984; Christenfeld, Wagner, Pastva *et al*, 1989; Delvin, 1992; Tyson, Lambert and Beattie, 2002) staff generally saw changes to refurbishment positively (Tyson *et al*, 2002).

The ecosystem model research discussed above does go some way in explaining and linking physical improvement and change to the enhancement of social atmosphere of the ward or department.¹⁵ In doing so though, they fail to identify the effects of the underlying philosophical influences on the structure such as security and control, and how the physical security measures can influence staff behaviours.

¹⁵ Ecological psychology suggests that human groups seek to adapt their buildings to their behavioural needs or functional requirements. Correction of this problem takes place through renovation, constructing and moving.

Staff responses to high levels of security, closed work environments and security related discourses have been identified in research in prisons and prison officer culture. The 'pains of imprisonment' (Sykes 1958; Toch, 1977), the deprivation of liberty, possessions, and security (Hood and Sparks, 1970) has not only been applied to prisoner populations but also to prison officers (Carter, 1995; Crawley 2000, 2004a). The experiences are similar in that the physical environment is the same as those who the worker is imprisoning, and during work hours both prisoner and prison officer experience similar discourse exertions from the organisation which they either represent or are held in custody by. The dearth of literature on occupational culture in mental health nursing raises similar questions on the extent of influence that modern psychiatry has upon those who administer mental health care, not least in terms of its representation in the physical fabric of the ward environment.

The Visible & Invisible

The complexity of modern-day psychiatric nursing care is characterised by high levels of demand upon the workforce. Daily challenges from service users and frequent service reforms typify the modern construct of clinical practice within acute mental health settings (Cleary, 2004). Recently researchers and practitioners have sought to explore the challenges and demands of the modern nursing workforce, resulting in numerous studies of medical and social reality of a variety of nursing care settings nationally and internationally (for example, Cleary, 2004; Hummelvoll and Severinsson, 2001; O'Brien and Cole, 2004; Johansson, Skärsäter and Danielson, 2006). In addition, studies have involved capturing the realism of some of the more salient issues surrounding mental health work such as the high risks of violence and aggression (see, for example, Jackson, Clare and Mannix, 2002; Carlsson, Dahlberg and Drew, 2000) and the changing complexity of care cases and 'difficult' to manage individuals (Breeze and Repper, 1998).

One particular issue features significantly amongst the literature discussing challenges and demands in mental healthcare. A National Health Service which is engrossed in various forms of change, reform, modernisation and restructuring is widely seen to underpin the physical, cultural and psychosocial aspects of care. Particularly, difficulties such as the diversity of service encounters, not least the predicament which all registered mental healthcare staff endure – the simultaneous role of providing secure but caring and therapeutic services (Mason and Mercer, 1998; Porter, 1993; O'Brien and Cole, 2004).

Change and reform is, therefore, undoubtedly manifested within what Cleary (2004) describes as *visible influences* and the *invisible background of nursing*. Visible change is witnessed in various forms such as: high bed occupancy, complex care planning for patients exhibiting challenges in terms of their definition of illness and behaviours and the rising number of individuals being nursed who display symptoms of poly drug misuse, dual diagnosis¹⁶ and personality disorder. Cleary (2004) goes on further to describe an *invisible background to nursing* where menial tasks are carried out that are necessary but detract the nurses attention from therapeutic caring. However, this invisible background to nursing extends further than Cleary (2004) defines. The behind the scenes systems of managing change and organisational objectives are also influential to the complexity of everyday nursing conditions and practice. Economic problems and increased demands of efficiency, productivity, effectiveness and accountability (Pettersson and Arnetz, 1997) give rise to concern over the nurse's ability to manage such situations successfully.

¹⁶ Dual diagnosis refers to mental disorder which is accompanied by substance misuse for example illicit drugs or alcohol

Chapter Summary

Mental health services are subject to much expedience both in the sense of the politicisation of treatment and control and conceptually through the dominant character of coercive discourses such as psychiatry. It is clear that such circumstances remain fluid and dynamic, with initiatives such as the DSPD programme redefining the principles of psychiatry in its tenuous tight-rope walk between treatment and security, care and public protection. Legislative redesign in the field of mental health care appears to have developed an all-encompassing framework, thus supporting the main criticisms of the anti-psychiatry movement who raise concern over the developing alignment of psychiatry with the legal profession and a departure from medicine. It is perhaps becoming more and more evident that mental health services are becoming less tolerant of positive risk taking, and that once again control and security has raised its head above the parapet in the care and treatment agenda.

Such a situation is challenging to exist within. Clinical staff are subject to role tensions and the problems that associate themselves with this are likely to be felt widely. Chapter 3 builds upon some of the implications for those working within professions that share similar occupational mandates in order to attempt to gain an understanding of the social and cultural dimensions to occupational life.

CHAPTER 3

CARE VERSUS CONTROL; THE SOCIAL & CULTURAL DIMENSIONS OF WORK

Daily work is not always subject to close inspection by superiors. They [employees] must get on with the job, often in difficult and hostile surroundings.

(Carter, 1994, p.56)

This chapter addresses the question of ‘how do workers cope with their occupation?’ This chapter draws upon theoretical concepts already influential within sociological studies of occupations. Here, concepts from occupations which share similar environmental and ideological characteristics (for example, the police, prison service staff) are evaluated. Considerations are made of the occupational cultures, working personalities and coping strategies utilised within other occupations. Emotional labouring is once again discussed and so too is the emotion and ‘performance’ management strategies adopted.

Work, similarly to more general social encounters and interactions, consists of a variety of influences upon behaviour. Institutional (structural) and face to face (interactional) influences visibly and covertly stimulate and channel the social actions within the organisation. Rules, value commitments, obligations of membership and shared expectations are just some of the examples that reflect in workers’ behaviours and their interpretation of the social world of work. The maintenance of stability (or social order) within the organisation will be dependant upon the extent to which workers conform to the formal rules and informal norms of the workplace.

The broad aims of this thesis explore the very grounding of mental health work and how this work is done. To attempt to provide some understanding of the nature of occupational social action and social order, then what follows in this chapter is an evaluation of key structures found in comparative occupations and strategies which staff have been found to utilise in their areas of work. Once

again, particular focus is placed upon the experiences of those within criminal justice occupations where nursing based literature becomes devoid of evidence.

Herbert's 'Normative Order' of Police Culture

The analysis of the social world initially deliberated by classical theorists such as Durkheim, Marx and Weber has been developed significantly over the course of contemporary sociology. One of the many sociologists adopting a revisionist and developmental approach towards classical thought was Talcott Parsons (1937).

The work of Talcott Parsons (1937), occupied a structural functionalist standpoint whereby interest and exploration of social action was firmly based upon the interactions of societal institutions and the development of the behaviour of social actors. Functionalism focused upon key areas of social arenas such as; function, interdependence, consensus, equilibrium and evolutionary change. In the functionalist view, all of these contribute to the formation and adaptation of social groups and actor's behaviours. At the same time, structural functionalists consider that there is an abundance of consensus of the norms and values which shape individual behaviour and these are generally agreed upon by social actors. Additionally, social change, in a functionalist view, is represented as being evolutionary and ordered rather than being rapid, chaotic or dramatic.

Central to Parsons' (1937) work is the maintenance of social order. This strand of his work did not believe that an individual's behaviour was not influenced by those surrounding them. To this end, he viewed that if individuals did actually pursue their own self interests, then society would be representative of total disorder. Parsons (1937) acknowledged that social actors were influenced by their own value set, but their own values (and consequently their actions) were constrained and regulated by the observations of normative actions of others - for Parsons (1937), this was the basis of social order.

In recognising some of the components of social order, how it is constructed and maintained, Parsons (1937) posits that there is a broad plethora of observable systems at work in society as a whole, and also smaller divisions of society or subsystems (for example, family, religion, occupations). According to the work of Parsons (1937), each system is characterised by cultural artefacts (often represented by certain rituals, symbols or shared beliefs) or personalities that regulate the boundaries. Parsons (1937) puts forward that social actors can be observed as being organised into separate grouping that are defined and structured by their agreed norms. The development and sustained maintenance of norms within each system is dependent upon the social action(s) occurring within that particular system, and thus, norms of that group influence the social order of that group.

The stability of systems, and in turn, those members who abide by the norms and values of their group are seen as key ingredients of social interactions and the development of the wider socialisation process. The socialisation of individuals within the bonded constraints of norm and value structure of a group or system, according to the functionalist tradition, is influential in the adoption of, and internalisation of norms (sustained maintenance) of that system or group. This process of the internalisation of norms projected upon an individual are believed to be central to the individual being motivated to act appropriately (Wallace and Wolf, 1999) within social encounters and experiences.

Yet, much of Parsons' (1937) work and structural functionalist perspectives have been heavily criticised and in part abandoned by modern sociologists (for example, Anthony Giddens) due to criticism for a lack of attention towards conflict and its impact upon social ordering. The sentiment of consensus is profoundly flawed according to critics of Parsons' (1937) work suggesting that there should be more recognition of potential for conflict between norms, values and actors in the analysis of social order. Where disputes and conflict appears within norm structures, these provide important indicators of the functioning of these groups and ultimately the character of opposing individuals and groups.

However it is necessary to observe structural functionalist interpretations as these hold the requisite components of social thought that enable sociologists to develop, discuss or disregard the contribution to expertise. Parsons' (1937) work provides a basis for understanding the nature of social action and social order (action theory) and provides potential for development in identifying and the position of conflict within the 'order' of societies.

An example of the acknowledgement of Parsons' (1937) work, and subsequent development in light of criticisms is that of Herbert (1998) in his study of American police officers. Herbert (1998) provides a revisionist approach to occupational subculture in policing. In doing so, he illustrates the shortfalls in previous exploration of this discipline and illustrates the importance of the main dimensions of formal rules and informal norms in the production of police action.

For Herbert (1998), previous research completed in the area of policing has demonstrated an over concern with sharp distinctions between formal and informal, bureaucratic regulation and the less formal ethos of police subculture. Herbert (1998, p.344) suggests that these dimensions of formal and informal 'co-mingle' and warrant exploration. Secondly, Herbert (1998, p.344) posits that research conducted so far has presented findings of 'police subculture as a more or less cohesive whole'. In addition, authors and researchers who pigeon-hole workers into specific groups according to their attitudes towards their work are equally restrictive in gaining an insight into police subculture.

Herbert (1998, p.345) describes the gap in the knowledge surrounding police subculture as:

[The necessity to] ..capture the formal and informal group-wide dynamics that constitute the police as a distinct group while also providing a means to adequately capture internal variations.

Herbert (1998) acknowledges the difficulties in collecting and identifying the various cultural and behavioural characteristics and components which contribute to a culture. Herbert (1998, p.347) takes heed of previous analyses of culture in observing that 'action is often goal directed' and that certain social situations are loaded with meanings and values. For Herbert (1998, p.347), these 'valued meanings may in fact be largely unconscious and internalised' and the analysis often stops at the point where worker's action is shaped by un-stated or unconscious norms.

Herbert (1998) discusses the work of Chan (1996; 1997) and the application of a Bourdieuan analysis to the daily practice of police work adopting a concept of 'habitus'¹⁷. Human dispositions are central to the phenomenon of 'habitus'. Bourdieu (1977) puts forward an argument that individuals function in the manner which they do socially in response to durable dispositions which have been built and retained over a history of acquired experiences. Everyday experiences, particularly those which have impacted the greatest upon an individual, and also those which may be retained in a sub-conscious manner, are thought to guide occurring social actions. Ostrow (1981) describes this further as:

[H]istorically developed social formations- that is the meaning of socio-culture itself- are grounded in the collective functional meanings and rhythms of everyday life.

(Ostrow, 1981, p.282)

'Habitus' provides the notion that no social action or thinking is a pure individual response, but rather a response which is built and developed from historical experiences of similar situations and encounters. These dispositions to act in particular ways are configured through years of experience within various cultures and sub-cultural groups, and determined through interpretation and experience of the 'field' and levels of 'capital' involved. The production of values within a culture is therefore not necessarily responsible for the particular social actions which occur, but as Swidler (1986) puts forward:

¹⁷ Bourdieu's (1977) third and final element of his construction of a *Theory of Practice* is *habitus*

Culture influences action not by providing the ultimate values toward which action is orientated, but by shaping a repertoire or “tool-kit” of habits, skills and styles from which people construct strategies for action.

(Swidler, 1986, p.273)

This repertoire of skills is constructed of both explicit and implicit examples (Rhynas, 2005). Habits and styles may be constructed or influenced by explicit traditions that surround the individual, such as particular cultural customs (for example, religion), but also as Rhynas (2005) states, is influenced by implicit examples such as modesty and manners.

Drawing upon Bourdieu's (1977) concepts of 'field' and 'habitus', and adopting a framework by Sackmann (1991), Chan (1996) offers an alternative analysis of Police cultures in Australia. Chan (1996) integrates Bourdieu's (1977) concepts with that of classifications of cultural knowledge put forward in the cognitive model developed by Sackmann (1991). Sackmann (1991) distinguishes four categories of cultural knowledge within organisations, and suggests that groups utilise aspects of knowledge collectively in order to make sense of realities. The arrangement of thoughts, methods of interpretation and integration of these thoughts and ideas, and the methods adopted in producing value systems and theories of the social world are divided into four dimensions of cultural knowledge. Sackmann (1991) describes the four dimensions of cultural knowledge which Chan (1996, p.113) presents as follows. (i) Dictionary knowledge – labels and definitions of items, events and things within an organisation. (ii) Directory knowledge – descriptions of 'how things are done' within the organisation. (iii) Recipe knowledge – prescribes what should or should not be done in certain situations, and (iv) Axiomatic knowledge – fundamental assumptions about 'why things are done the way that they are' in an organisation.

Within the work of Chan (1996), and with the influence of both Sackmann (1991) and Bourdieu (1977), a complex exploration of police culture has been undertaken. The use of Sackmann's (1991) model of four dimensional cultural

knowledge has further extended the scope of analysis using Bourdieu's (1977) framework of 'field', 'capital' and 'habitus'. The interactions taking place in the 'field' of policing, the interpretive aspects and habits of police officers and the co-configuration of these concepts against dimensional cultural knowledge have presented, what Chan (1996) describes as:

[A] model of police cultural change that emphasises the relationship between the social, legal and organisational context of policing and the schemas, classifications, and vocabulary of precedents central to the craft of policing.

(Chan, 1996, p.131)

Yet, Herbert (1998) illustrates two major shortcomings in the work of Chan's (1996; 1997) application of 'habitus'. Firstly, Herbert (1998, p.350) considers that although the application of 'habitus' maybe intuitive, at the same time it is vague and difficult to pin point 'exactly what constitutes a disposition or how one could go about denoting or describing the contours of 'habitus' in the investigation of police culture. Secondly, Herbert (1998, p.350) questions the possibility of 'capturing conflict within a given habitus'. The use of 'habitus' therefore would perhaps provide a *macro* level analysis of the functions of an occupational culture, but would provide little insight into the dynamic *micro* level structure, conflict, instability and variation within a specific occupational subculture.

Herbert (1998) advocates for the use of a developed 'normative order'. Herbert (1998, p.347) describes normative order as:

[A] set of generalised rules and common practices orientated around a common value. Given social worlds consist of varied collections of such orders, which together provide guidelines and justifications for actions of members of the group.

Herbert (1998) acknowledges the potential contribution of Parsons' (1937) work. He is cautious in its application to his study of police culture, but nevertheless presents an analytic framework of observing police culture built upon perspectives put forward by the early work of Parsons (1937). Herbert (1998)

demonstrates how Parsons' (1937) work neglects to consider the elements of reflexivity and the cognitive construction of rules for social interaction. For Parsons (1937), behaviours are developed by the influence of other social actors, where-as Herbert (1998, p.348) states that although internalised values are important, they are complimented by 'structured improvisations' of human action in reaction to social situations.

Secondly, Herbert (1998) recognises the neglected attention of Parsons (1937) toward conflict. Conflict between social actors, the impact upon members of a social group and the potential outcomes manifested in action are, by Herbert (1998), seen to be highlighted by the adoption of a normative order framework. It achieves this via 'opening an analytic window onto conflict by elaborating a variety of orders and their potential contradictory tendencies' (Herbert, 1998, p.350) and advocating for an 'analytic tool that is flexible to understand the variety of ways in which conflict is engendered'. (p.348)

Building upon initial work completed by Talcott Parsons (1937; 1951) in the area of social action and social cohesion, Herbert (1998, p.348) defines his use of normative order as 'a set of rules or practices centred on a primary value'. For policing, Herbert (1998) has provided six normative orders to police work; law, bureaucratic control, adventure/machismo, safety, competence and morality. Crucially, each normative order may be defined differently at any time; however, it resembles a consistent attribute to the line of work which the individual is engaged within. Though in the structuring of the social world of an occupation, according to Herbert (1998, p.361), the normative orders which have been identified in his study of LAPD police officers 'provide different sets of rules and the practices that officers use to define situations and to determine their response... and infuse the world view of the police with emotive significance'.

The application of the six specific elements of normative order (law, bureaucratic control, adventure/machismo, safety, competence and morality) in policing which Herbert (1998) has applied, in part are applicable to other

organisations. Herbert (1998, p.364) states that ‘many of the normative orders common to police organisations, such as bureaucratic control, competence and morality, are found in other social groups... and that the collection of normative orders [in other occupational groups] will be the source of the group’s uniqueness’.

Herbert’s (1998) analysis of police culture has provided a structured and alternative lens through which occupational cultures may be observed. As has been discussed in earlier parts of this thesis, exploration of criminal justice occupations has revealed many similarities and shared concepts with that of mental health work (for example, occupation characterised by extremes, administering levels of formal social control). Herbert (1998) has successfully explored the many social facets of police work, and through a systematic framework, acknowledged many of subtle and provocative attitudes and work behaviours of LAPD officers. In doing so, Herbert (1998) has been able to identify conflict and also pay particular attention towards variations (for example, occupational status) within a single occupation.

Herbert’s (1998) normative order framework can be seen in a developed and adapted form in the findings and analysis of this thesis as it is presented as the core theory of this study.

Organisational Culture & Occupational Sub-cultures

Culture exists when people come to share a common frame of reference for interpreting and acting toward one another in their world. In observing culture and its formation, often they are characterised by visible; customs, traditions, rites, rituals, stories and myths (Trice, 1993).

A key strand within contemporary examinations of work relates to organisational and occupational cultures (see, for example, Smircich, 1983; Williams *et al.*, 1993; Fineman and Gabriel, 1996). Such analyses have pointed

to the way in which occupational cultures impact upon the performance of organisations, in particular the potentially deleterious effect of informal work cultures. Within the psychiatric field, the cultural production of negative attitudes towards the diagnosis of personality disorder has received much attention (Bowers, McFarlane, Kiyimba, *et al*, 2000). In light of these potential problems, many organisations are seeking to achieve cultural change through initiatives in for example, recruitment and training (Williams *et al.*, 1993).

Numerous definitions are available to identify what is best described as organisational culture (see for example, Schneider, 1988; Kotter and Heskett, 1992). However Schein (1991) offers a useful explanation when evaluating the definitions. Schein (1991) states that there are two levels of culture within an organisation, a visible culture where behaviour patterns, rules and the dominant values and philosophy of the organisation are observable. Schein (1991) goes on further to posit a second deeper, less visible layer of culture within organisations and work groups. This less observable element of the organisation's structure often referred to as informal work cultures or sub-cultures, consists of the value, belief and goal syntax which are integral to constructing norms within that particular work group. Trice (1993, p. xi) agrees, stating that 'organisations develop distinct sets of emotionalised, collectively held beliefs that impel members to act in certain ways'. Furthermore, Trice (1993) defines these beliefs as ideologies, stating that the ideas expressed through 'symbols, ceremonies, myths, rituals, stories, special languages, sagas, taboos and rites are the cultural forms that together with the ideological beliefs constitute the main ingredients of a culture' (Trice, 1993, p. xi). In observing what Schein (1991) describes as informal work cultures, Trice (1993) states that subcultures differ considerably from the core culture in which they are embedded. According to Trice (1993) the ideologies and cultural forms of these subcultures either enhance, or deviate from the ideologies of the core culture of the organisation.

'Addressing culture within organisations is increasingly seen as an essential part of health service reform' (Scott, Mannion, Marshall and Davies, 2003, p.111).

Like many large organisations and public agencies, change, transformation and reform are witnessed as locus of control for developing functionality, performance and quality. Several studies have identified the significance of culture and cultural elements in achieving positive change within the National Health Service (MacKenzie, 1995; Ashburner, Ferlie and Fitzgerald, 1996; Brooks, 2002; Scott, Mannion, Davies *et al*, 2003). These studies have shown the managerial, bureaucratic and political influences on attempting to not only reform the organisation, but through methods of shaping and manipulating work groups and informal work cultures.

Ashburner *et al* (1996) demonstrate how political legislative action has influenced change in the NHS through the NHS and the Community Care Act (1990). The visible surface culture of the National Health Service has developed as a consequence of this Act being introduced in what Ashburner *et al*, (1996, p.2) describe as somewhat of a 're-labelling exercise'. The growing political need for health services to become parallel in terms of their organisational development during the 1980s and 1990s to other private and central industries, led to the implementation of increased levels of managerialism. Neglecting to understand that the effectiveness of the organisation can vary as a function of its own culture(s) (Scott *et al*, 2003) would therefore make improvement in areas of performance, quality and functionality impossible.

The challenge for policy makers, managers and service reformers is how to attempt to reform organisational cultures both visible surface cultures and the less visible sub-cultural groupings. Quinn (1980 as cited in Ashburner *et al*, 1996) states that the process of change, both organisationally and culturally, must be 'owned by the employees'. A sense of empowerment for those who occupy the informal work cultures would benefit the transition of complex change. However external influences and centralised administration allows for the experimentation of culture changing from outside of the immediate worker's environment.

Resistance by sub-cultural groups to political and economic interference and forced cultural change may well be seen as a significant problem in developing a programme of health service reform (Brooks, 2003). Brooks (2003) provides an analysis of the implications of change on sub-cultural employee groups, and the characteristics which are maintained or developed which provide barriers between informal work groups and the potential for problems to develop from a *top-down* approach to cultural change.

Observable negative aspects of work group and professional autonomy are preserved by ritualised ceremonial activities and if these ceremonies can be changed, then positive breakthroughs may feed into wider organisational change

(Brooks, 2003, p.342).

Brooks (2003, p.344) goes further to describe an existence of 'tribalism' within sub-cultural groups. The tribal instinct in preserving the goals and values which already exist within their set culture are seen as intrinsic to organisations and professional groups which are large and complex and entail a large degree of routinised behaviours. Shaping, modification and the creation of new ceremonies to consolidate old and new ways with the removal of identified dysfunctional ceremonies is anticipated by Brooks (2003, p.350) to 'unlock the organisational culture' and move forward in service reform.

Researchers have explored some of the areas of culture within care settings, particularly the visible social structure created and influenced by the cultural system of the environment (see for example, Caudill, Redlich, Gilmore *et al*, 1952; Holland, 1993). Holland (1993) explored nursing culture for 'ritual' in a general ward setting, maintaining a focus on ritualised behaviours within staff cultural groups and their perceived detriment to patient care. Holland (1993) examined and searched for the patterns and aspects of the daily routine which make up the culture of the group within a general hospital setting. The cultural characteristics of the 'common enterprise of caring for the sick' (Holland, 1993, p.1467) were observed and divided into categories of social structure (for example the built environment), authority, economic system of 'social time',

communication and socialisation. The cultural setting was characterised by a sense of culture being ring fenced within a particular ward and it being constrained by the hospital building itself. Divisions of labour and rank-order were illustrative of the distribution of power and authority. Routines of ward were the main illustration of the cultural mechanics of the group, whereby set duties were carried out during the day and in a precise order. Communication amongst the working group, 'had its own language' (Holland, 1993, p.1466). Verbal and non-verbal languages were seen to organise the daily routine of the worker, for example hand-over dialogue and coffee time chit-chat. Finally, Holland (1993) examined the socialisation processes on the ward, specifically those of new student staff. Students were seen as transient and only able to experience brief aspects of the wards culture but maintained their own position within the social structure. Holland (1993) remarks that dialogue of senior staff alluded to a sense of ownership of the students, this was seen to have two purposes; to make the students feel welcomed and supported but also maintained their position in the rank order of the staff group. Holland's (1993) ethnographic study asserts there is little evidence that ritualised behaviours are harmful to individualised patient care and expresses the importance of socially cohesive groups of staff within their own cultural environment.

Role Conflict

Yet many values and beliefs of sub-cultural groups are built upon, and in reaction to, complex practical and conceptual aspects of the job. The nature of mental health work and the competing dilemmas of care versus control have been most comprehensively developed within the speciality of 'forensic' mental health nursing¹⁸. Although distinctly different, local mental health units do utilise some of the principles and practices of special hospitals and regional secure hospitals in maintaining effective treatment, safety and control of their clientele. Burrow (1991b) reviews some of the resources necessary in

¹⁸*Forensic Nurse*:- Literature on this subject refers generally to those nursing staff who work within the confines of Special Hospitals and regional medium secure units, caring for individuals who have committed or are at significant risk of committing criminal offences.

maintaining a 'security-consciousness' within hospital custody. Nurses wear sets of keys, search patients, operate electronic door locks and use two-way radios, and as Burrow (1991b, p.65) states, 'without doubt, a major part of the special hospital nurse's role centres on control'. Although surroundings, architecture and work environment differ from high/medium secure hospitals to local mental health in-patient provision, many internal security arrangements remain the same.

Control and security responsibilities of mental health nursing staff within local hospitals may well be diluted from those encountered by forensic mental health nurses. However, as will be seen there remains a potential for dilemmas to arise between therapeutic care and control of patients. Dyer (1991) explains the overarching quandry of practice facing mental health nurses. 'Nurses in psychiatric hospitals have a duty of care; a professional code of conduct and legal powers of detention and restraint.' (Dyer, 1991, p.47)

Many local mental health units have service provision for the care of individuals who require increased levels of security than open wards can offer. Psychiatric intensive care units (PICUs) are as Burrow (1993a) refers to as being 'traditional locked wards' complimenting services with a provision for minimum security needs. Patient escorts, locked doors, consensual and un-consensual searching of detained patients, room searches, therapeutic observation, restraint, enforced medication and limiting of possessions (for example, cigarettes, lighters, objects viewed as hazardous to the suicidal patient) are all common practices encountered by mental health nursing staff in the local unit environment. Local mental health in-patient services also experience a share of clients with previous offending history, and often PICU's receive a number of patients transferred from custody or diverted by the courts, which may or may not be restricted by the Home Secretary. Therefore, it can be seen that there are some aspects of daily duties which are similar to that of a forensic mental health professional, and that it is likely that mental health nurses of a

local unit encounter the care versus control dilemma also, albeit to a differing degree.

Analysis of role conflict completed within forensic psychiatric settings remains illustrative of concerns facing other mental health practitioners. Dale (1995) demonstrates the external and political influence upon expectations of nurses working within this profession:

On one hand, their [nurse's] professional ethics compel them to empower and support patients in achieving their rights. On the other, society demands that they control and restrict patient's rights in order to protect the community from potential harm.

(Dale, 1995, p.33)

Despite, multi-agency and multi-disciplinary working being the norm, it is nursing staff which are placed at the forefront of the challenges involved in such a situation. Burrow (1993b, p.21) remarks that other health disciplines 'afford the luxury of a more or less unadulterated therapeutic role'. Nursing staff, unlike psychologists, psychiatrists and social workers for example, maintain responsibility for the administration of control and security privileges. Mason (2002, p.514) states that 'as nurses have the longest contact with patients this suggests that they have the greatest opportunity to engage in therapeutic activity'. However, Burrow (1993b) suggests that even where nursing staff attempt to engage in therapeutic activity and goals, control remains an overriding and dominant feature of their staff role. Given this predicament, Dale (1995) puts forward that nurses should utilise their therapeutic engagement to establish therapeutic alliances that redress the power balances between staff and patients. The role tensions experienced by nursing staff are considered by Burrow (1993b) to be the responsibility of the nurse to marshal. However this is all increasingly difficult to complete as the emphasis on control can overshadow the therapeutic potential of their role due to the conceptual problem of power and authority over groups (Burrow, 1991a).

Professional dilemmas of role conflict are also compounded by nurse's socialisation within wider society (Burrow, 1991b). In the case of forensic nursing staff, attitudes towards certain patient groups are influenced by staff's individual attitudes towards the crimes that the patient has committed. In doing so staff must examine and come to terms with their attitudes of social deviations (Burrow, 1993b), although it is likely that situations for nursing staff will be untenable as it would be unreasonable to suggest that it is possible for a completely neutral staff view of offending patients. Their stance on this will 'derive from the diffuse social and political values they hold as members of a broader culture' (Burrow, 1993b, p.24).

Personal, political and social values all interject into the challenge of balancing therapy and control, and as Burrow (1993b, p.24) states, 'it cannot be assumed that forensic nurses can even attempt to come to terms with this role conflict'. The problems involved for nursing staff are, therefore, not only personal, but have implications for professionalism as a whole. Clear and unambiguous philosophies underpin the professional integrity of a discipline and have the potential to leave individuals with somewhat of an ill defined role (Burrow, 1993b), facing the intricate challenges of a 'custodial role fused with a caring perspective' (Mason, 2002, p.512).

The Working Personality

In addition to researching the more visible elements of staff cultures, organisational culture researchers have highlighted the strategies that enable employees working in emotionally charged environments (such as nursing staff, security workers and fire-fighters) to perform their daily duties (see, for example, Fineman, 1993; Hochschild, 1998; Hobbs *et al.*, 2003). Looking towards occupations sharing similar challenges and mandates as mental health nursing, an exploration of work cultures has been most fully developed in relation to the organisation of policing, police behaviour and identities (see, for example, Skolnick, 1975; Holdaway, 1983; Reiner, 1985; Jefferson, 1990;

Young, 1991; Heidensohn, 1992; Fielding, 1994; Waddington, 1999; Mawby, 2002). Holdaway (1983, p.134), for example, in his study of the British police, identifies the occupational culture of policing where officers construct an understanding of the nature of police work: 'what police officers think they *should* be doing and how they think this can be achieved'.

Policing may be seen as an occupation in which extremes exist; hours of boredom followed by minutes of sheer terror. The demands of the job mean that officers work in an unpredictable and stressful environment characterised by the potential for danger and violence. They also often have to assert authority and, increasingly, to demonstrate productivity. In response to these imperatives, it has been suggested that police officers develop a distinct 'working personality' (Skolnick, 1975, p.71). That is, they generate specific ways of thinking about and doing their job, which, together, constitute an occupational culture. Skolnick (1975) outlines the key characteristics of this culture, including a tendency towards cynicism, mistrust and suspicion, a sense of in-group solidarity and an 'us-them' worldview, conservatism and a liking for potential danger.

All occupational groups share a 'measure of inclusiveness and identification which is brought about by doing the same work and sharing the same problems' (Skolnick, 1975, p.52), and for the police this inclusiveness is represented by the sharing of the elements of the police milieu. Danger, authority and efficiency, according to Skolnick (1975), are the principal elements which contribute to the policeman's working personality and the occupational culture of the police. Skolnick (1975) states that elements of danger and authority that contribute to the construction of a working personality should only be interpreted in light of the context of constant pressures to appear efficient. The concept of a working personality is built upon the very nature of the work concentrating on the potential for violence towards officers. Skolnick (1975, p.67) states that measures of authority are used intrinsically within the job role to counteract and reduce the perceived threat of violence. Developing the notion that danger typically yields self defensive conduct, the authority characteristic is developed

within the personality of the police officer in order that it can be summoned as a resource in their daily confrontation with danger. However, Skolnick (1975, p.44) purports that this too is hazardous, as working personalities that rely upon a need for authority, reinforces that danger is manifested in the daily work in such occupations. This situation leads to the police being continually occupied with the potential for violence and a tendency to be suspicious.

The preoccupation of danger within the role of the police officer, and the development of characteristics of a working personality, according to Skolnick (1975), increases the potential for social isolation. The authoritarian aspects of the personality may well force a separation between the police officer and the public. Skolnick (1975, p.59) asserts that the fact that a police officer is 'engaged in enforcing a set of rules implies that he/she automatically becomes implicated in affirming those rules'. Furthermore, the occupational claims and costs over the daily existence of the officer extend beyond the official duties of the job and there is no doubt that an officer's outlook is affected:

What policemen typically fail to realise is the extent that he becomes tainted by the character of the work he performs. The dangers of their work not only draw the police together as a group but separate them from the rest of society.

(Skolnick, 1975, p.54)

The development of the distinct ways of perceiving and responding to their work environment, like other aspects of the job, will be a shared experience amongst workers. Skolnick (1975, p.52-53) reports that the police have unusually high levels of occupational solidarity. This may be attributed to by the sharing of a working personality, and exacerbated by a lack of public support and apathy. Additionally Skolnick (1975) states that through their job, and through a development of a working personality the police officer sees themselves as a specialist in dealing with violence and danger. However, despite this self assured expertise, officers are seen to look towards the solidarity of peers as they do not want to face the prospect of 'fighting alone' (Skolnick, 1975, p.53).

The process of interpretation of rules and boundaries of work cultures is subjective. Belief and value attitudes held by workers are often influenced by not only the collective ideologies of the (sub) culture, but also by more personal aspects such as occupational self image. Occupational imagery can provide work motivation and satisfaction (Simpson and Simpson, 1959) and in certain job types, social prestige. Imagery that focuses upon the administrative principle (Freison, 1973 as cited in Trice, 1993, p.145)(for example, '*doing the job as they think it should be done*') or of the dominant values of the culture (for example, care of the patient versus control of the patient) are seen in some instances to perpetuate more favourable evaluations by others in the group. The visible and conceptual aspects of self-image that is so heavily influenced by the beliefs held within the working personality or 'canteen culture' has been most comprehensively developed within studies of prison officers. Occupational typologies often provide a visible demarcation between occupational subcultures. The ways in which workers think about their job, the ways in which they think their job should be done, formal rules of the establishment and informal rules of the sub-culture are intrinsic elements of the value and belief structure of occupational groups. In studies completed in criminal justice occupations (for example, Kauffman, 1988; Fleisher, 1989; Crawley, 2004) differences in opinion and beliefs between groups is illustrated, often in the dialogue of employees, by certain worker 'types'.

Kauffman (1988) states that prison officers respond to their environment characteristically in different ways. These observations consisted of a comparison between attitudes towards fellow officers and attitudes towards inmates. Five typologies of officer were developed according to responses and attitudes to each individual. These groupings of staff not only illustrate how prison officers conduct their role in light of the way in which they interpret the job, but also the divisions which emerge between sub-cultural groups of staff based upon competing beliefs on *how* each group think the job should be *done* (see *table 1* below and *appendix (i)* for an overview of prison officer typologies).

Attitude Towards Officers				
Attitudes Towards Inmates		Positive	Ambivalent	Negative
	Positive	Pollyannas		White Hats
	Ambivalent		Functionaries	
	Negative	Hard Asses		Burnouts

Table 1, Typology of officers according to attitudes towards officers and inmates (Kauffman, 1988, p.249)

Kauffman's (1988) typology of prison officers has been further developed by Carter (1994). In an ethnography of British prison officers, Carter (1994) observed that just three typologies existed, 'Black and Whiter's', 'Weathermen' and 'Easy Lifers' (see, *appendix (i)* for an overview of prison officer typologies). Within these categories of staff, Carter (1994, p.55-56) highlights the 'shared, recognisable perspectives of action' within the occupational culture of prison officers and some of the strategies of dealing with everyday realities of prison life.

Carter (1994) considers the potential conflict between the working styles of different officers, yet it appears that for the majority of time, opinions of other peoples work practices is confined to 'off stage'(Goffman, 1959) or 'staff only' areas. Carter (1994, p.54) states that 'keeping face' is regarded as fundamental amongst officers and undermining one another in the presence of inmates is not usual practice as the common aim of maintaining order is the concern of all staff.

Various writers have developed Skolnick's (1975) concept of the working personality, suggesting that 'cop-canteen' is also characterised by machismo (see, for example, Reiner, 1985; Fielding, 1994; Jefferson, 1990). Within such a culture, which 'provides the practical common sense 'rules'' for police officer's

daily duties (Jefferson, 1990, p.47), racism and sexism have also been shown to be institutionalised.

The interposed values of police cultures have widely been considered as those of a 'machismo' nature. These have perhaps originated from the neglect of Skolnick (1975) to observe characteristics of women police officers. However, many of the components and values that are contained within characteristics of the cop-canteen culture remain orientated towards concepts of hegemonic masculinity. Fielding (1994, p.47) describes stereotypes 'revolving around the physical resolution of direct violent confrontations' and the 'preoccupation with imagery of conflict'. The 'toughness' value of the culture and the 'excitement of danger' (Fielding, 1994, p.50) are further developments of the working personality described by Skolnick (1975). However, despite values of the police's working personality and cop-canteen culture containing strong 'macho' tenets such as; authority, violence and danger, Fielding (1994, p.52) questions 'whether these are rooted in the masculinity of the officers or whether they are responses to the demands made by the occupation?' Fielding (1994) pays particular attention to the fact that this question may not be possible to answer succinctly. According to Fielding (1994, p.59) the Police are not alone amongst social institutions in falling under greater scrutiny and scepticism within a 'crisis of legitimacy'. This situation places increased demands upon officers in interpreting what they think about their job and how they apply the rules of the job. It is already known that levels of resistance amongst workers increases as innovations threaten work practices in the field (Fielding, 1994, p.46), exacerbating the 'hard-bitten' and cynical outlook on the job and social world. Fielding (1994, p.63) concludes by offering that occupational groups and the cultural values within them cannot be simple distinctions of 'masculine' or 'other' denominations. Work cultures are invariably linked by both individual characteristics of members, but also by the structural features of the occupation which surrounds them and the demands made on them.

It has already been seen that there will be variances in the value systems of cop-canteen cultures and there is evidence that not all police officers are alike in their working personality. Researchers of police have identified multiple cultures within police work (according to variables such as age, rank, location and so-forth) and various writers have developed typologies about styles of policing (see, for example, Fielding, 1994). Skolnick (1975) also points out that many of the characteristics of police culture may well be found in other occupations sharing similar problems. For example, members of the armed forces are, similarly exposed to danger. However, Skolnick (1975) argues, that it is the combination of elements, which may be specific to the occupational group, which generates distinctive cognition and behavioural responses.

Examples of the occupational cultures within psychiatric settings are limited, yet those available unveil significant evidence of attitudes of staff and responses to the demands of the job. The behavioural responses of nursing staff in these studies appear sided with sub-cultural pre-requisites of a necessity to impose high levels of control towards patients. Studies completed by Morrison (1989) and Mason (1993) bring attention of how sub-cultural attitudes impose upon the actions, attitudes and decision making processes of nurses, not least in terms of responses towards the dilemma of care versus control.

Morrison (1989) illustrates behavioural responses to workplace value systems and what may be considered as a particular working personality of a psychiatric hospital ward. Morrison's (1989) study examined the conduct of non-professional psychiatric nursing staff, their occupational values and the impact of these on patients in their care. The research area is characterised by regular violent episodes and similar to police work, the potential for danger is apparent along with a necessity to maintain security and be authoritative. Morrison's (1989) study unveiled many of the cultural values which can be associated closely with other occupations' cultural value systems and working personalities which have previously been discussed in this section.

Morrison (1989, p.34) describes how violence experienced within the confines of the ward were rationalised by staff. Violent behaviour was viewed as a symptom of an illness and within such a medical ideology, there is a strong emphasis on the values of control and safety. The potential for violence is an everyday confrontation, and authority and staff solidarity are utilised to maintain what is seen to be the correct outcome where 'doing a good job means keeping patients under control' (Morrison, 1989, p.34). The socialisation process of new staff is further explored by Morrison (1989). She identifies that the working personality and sub-cultural values of control and enforcement are seen as existing exclusively within this environment. Staff not subscribing to these values of the dominant culture faced isolation and potential danger. Reciprocity is used as the primary mechanism for forcing compliance of cultural values for new staff. Morrison (1989) describes how staff who attempted to de-escalate situations verbally were seen as time wasters and in the future staff would not respond to calls of assistance from that particular employee. It was regarded that physical intervention was necessary in the first instance in order to be seen to be carrying out the job as *they* see that it should be done. This working personality or as described by Morrison (1989) as 'the tradition of toughness', demonstrates the use of a preferred ideology based upon authority models of care. The roots of this tradition may be seen as a response to the demands placed upon the healthcare workers, in an environment characterised by a potential for violence, and staff responding in a unitary manner and in a way that is legitimised in their own understanding of the expectations of the job. Additionally, these behavioural responses may also be influenced by historic value systems of the care of the mentally ill. As Morrison (1989, p.36) states, the findings from this study are consistent with research of the asylums completed in the mid-twentieth century, whereby inpatient care is symbolic of a coercive and regimented care approach.

Crawley (2004) applies Skolnick's (1975) concept of working personality to the study of prison officers, suggesting that there are distinctive responses to 'doing' prison work (also see Crouch, 1980; Kauffman, 1988; Carter, 1994).

Crawley (2004) argues that prison work needs to be seen as 'emotional labour' and that prisons are not just disciplinary establishments. They are, at the same time, emotional and highly domestic arenas in which prison officers are often subject to profound emotional and psychological pressures (often exacerbated by political imperatives and poor staff-management relationships). Crawley (2004, p.39) explains that a large number of staff attempt to 'resist the negative values, beliefs and attitudes of the 'guard' subculture'. However what is observed is the variety of occupational and peer pressures placed upon prison officers.

Crawley (2004) analyses the (often contradictory) role-set of prison officers, the occupational socialisation processes and the strategies utilised to keep emotions in check (for example, the use of humour and banter). Additionally, she draws attention towards the destructive potential of one or a number of the environments upon staff sub-cultures. Affiliation and socialisation into some sub-cultural groups (dependant upon the characteristics of the working personality values which are held) may well have the potential to lead to de-legitimisation of the prison regime. Crawley (2004) posits that the quality of work cultures and their values impact directly upon the quality of imprisonment for inmates yet the quality of a work culture is difficult to gauge in an environment where the *mission* of the prison officer has become blurred, with a confused view of what a prison officer is supposed to do or be' (Crawley, 2004, p.41). In light of this, some staff views themselves in a quandary within the socialisation process. Strategies which are adopted in order to emotionally deal with the challenges of the work day often become regulated, not only by the individual but are also influenced by occupational sub-cultures. In her analysis, Crawley (2004, p.251) states that the failure of a staff member to 'display the correct emotional responses, in the right place and at the right time', leaves the officer at risk of becoming excluded from particular occupational groups and becoming an occupational 'deviant'.

Crawley (2004) argues that many of the cognitive and behavioural responses to prison work are similar to those found in policing (for example, cynicism,

mistrust, machismo and in-group solidarity). However, her analyses also suggests that not all prison officers view their role (of care versus control) in the same way and that not all officers are alike in their demands and pressures of the job. Conceptually, the jobs differ in that Crawley (2004) describes the police dealing with the 'acute' phase and prison officers treating and addressing the 'chronic' phase of the criminality. Police officers encounter the assailant for a relatively brief period, where-as prison officers are tasked with longitudinal contact and the maintenance of the prison *status quo*. According to Crawley (2004), despite the similarities between policing and prison work, the strengths of these similarities is dependant upon work conditions and the context of the prison work environment. Additionally, occupational cultures and the working personalities maintained within them is largely variable dependant upon the type, function and history of a particular prison. In her analysis, Crawley (2004) suggests that it is too easy to assume a popular opinion of a single prison officer culture, and that instead of a single dominant work culture and due to the diverse interpretation of 'vision' and 'version' of the prison officer role, occupational culture within prison organisations should be regarded as a collection of cultures.

Performance Management

An important strand of this thesis attempts to explore how mental health work is experienced, and through this, how social encounters are managed and how socialisation into the workplace occurs. Hospital work, like prison work engages in client-staff encounters on a daily basis. At times these encounters may be emotionally charged, for example, restraint or a conflict of views. Organisational governance demands that the worker must maintain levels of professionalism, even in adverse situations. In an examination of how these encounters are managed or achieved, concepts of emotional labour and performance management become important in this exploration and provide a theoretical framework that goes some distance in explaining some of the ways in which occupations experience their work.

In Crawley's (2000; 2004) study of prison officers, focus is placed on the importance of the 'emotional work' and 'emotional labouring' of officers, a theory first put forward by Hochschild (1983). Hochschild (1983) in her study of flight attendants proposed that in work areas that either involve high levels of emotional stresses or roles where customer or client interaction is the norm, then workers personal emotion is managed.

Crawley (2000; 2004), like others who have explored 'emotional labouring', have demonstrated that this is multi dimensional and not a phenomenon which is confined to Hochschild's (1983) study of flight attendants, but an issue which is poignant in investigating occupational cultures in any workplace.

Hochschild (1983) suggests that workers suppress personal feelings and emotions in order to sustain outward expression that produces the proper state of mind in others, for example customers or members of the public. These methods of feigning an appropriate emotion or image (Mann and Cowburn, 2005) have directed further revisionists of the study of 'emotional labour' (for example, Bolton, 2001) towards the study of acting, face changing and the workplace as 'theatre', most notably documented in Goffman's (1959) work of presentation of self in social interactions.

Nursing, like prison work, is an occupation considered to contain the components of emotional labour (Mann and Cowburn, 2005). Working in an environment where extremes exist and much of the job may be considered as domestic in nature, mental health nurses work in an environment where there is potential for violence and where there is a necessity to perform and manage emotion on a daily basis. The process of managing these emotions is the centrality of the concept of emotional labour, and Hochschild (1983) posits that emotional labour is the management of feeling to create a publicly observable facial and bodily display. Furthermore, Henderson (2001, p.30) explains emotional labour and the *acting out* of a desired demeanour as 'a label to capture a notion of costs and benefits to members of a profession in which the

manifestation of feeling, designed to influence clients, are required components of job performance’.

Exploration of ‘emotional labour’ encountered by criminal justice occupations is limited to two studies (Rutter and Fielding, 1988; Crawley 2000), yet much research has been completed in the context of the healthcare setting (see, Smith, 1988, 1992; James, 1992; Froggatt, 1998; Bolton, 2001; Henderson, 2001; Sayre, 2001; Mitchell and Smith, 2003; Mann and Cowburn, 2005). Authors have justified their reasons for investigating the nursing profession in that emotional labouring is intrinsic to the development of social relations with service users and patients, and has the potential to positively assist and cultivate care pathways to recovery (James, 1992; Gray, 2000; Mann and Cowburn, 2005). Additionally, health service reform, managerialism and for-profit Foundation Trust services form a backdrop of structural changes affecting the nursing workforce in terms of how staff present themselves to patients, service users and stakeholders more alike to social interactions in retail where customer satisfaction is of considerable importance. Bolton (2001) posits that this necessity to perform to organisational expectations or the ‘requirement to regulate emotional displays to meet organisationally based expectations of specific roles’ (Brotheridge and Lee, 2003, p.365) is integral to achieving social membership within the organisation or occupational group. This notion of mandatory ‘rules of feeling’ within employment environments suggests that employees will constantly need to act and conform to the organisations ideology, and in not doing so, accessing and maintaining a position in such an organisation or occupational group would not be possible.

The manner in which workers manage their emotion and their situation of what MacDonald and Sirianni (1996 cited in Fineman, 2000) describe as being an ‘emotional proletariat’ direct thinking towards the nurse as a social actor. In what Goffman (1959) describes as ‘frames of action’ nurses must perform in several different *scenes* in order to portray the correct demeanour to various groups (for example, other staff, managers, subordinates, patients, visitors,

doctors). Presenting faces of either ‘cynical’ or ‘sincere’ (Goffman, 1959), surface or deep acting (Hochschild, 1983) indicate the divisions in the ‘presentation of faces’ to others. The former, ‘surface acting (or cynical) involves the expression of behaviour rather than feelings’¹⁹ (Williams, 2003, p.516 cited in Mann and Cowburn, 2005), and the latter, deep acting (or sincere) involves the ‘actor attempting to actually experience or feel the emotion that he or she wish (or are expected) to display’ (Mann and Cowburn, 2005, p.154). Both surface and deep acting provide the underlying psychological approaches made by workers prior to an encounter.

An additional dimension of nurses approach to social relations, and particularly reviewed in the context of the staff – patient relationship by Henderson (2001, p.132) is the process described to entail both detachment (objectivity) and engagement (subjectivity). The purposes of engagement and detachment invariably impact upon the levels of emotion involved in the social encounter, and it is argued that a lack of the *correct* emotion towards patients can be to the detriment of their recovery, yet detachment maintains its utility in the process of self protecting of personal emotions through what is described as ‘benign attachment’ (Fineman, 1993; 2000). For nurses interviewed in a study conducted by Henderson (2001), detachment offered a means by which personal reflection seen in patients is managed successfully in order to limit the personal costs upon the *self* of emotional labouring.

Nurses are seen as accomplished social actors (Smith, 1988; 1992; Bolton, 2001) and nursing staff must negotiate certain ‘rights of passage’ in order to learn how to be competent emotional labourers (Smith, 1988; 1992). Bolton (2001) suggests that nurses are ‘emotional jugglers’ and integrates Goffman’s (1959) concepts of dramaturgy and encounters within Hochschild’s (1983) theory of emotional labour to the nursing workforce. Bolton (2001) recognises Hochschild’s (1979) criticisms of Goffmanesque theory in that Goffman (1959) underestimates the effects of social actions and encounters upon the inner self,

¹⁹ For example ‘blocking out feelings’ (Staden, 1998 cited in Mann and Cowburn, 2005)

providing evidence of only surface acting and not deep acting. Nevertheless, as Bolton (2001, p.86-98) illustrates, Goffman provides some important perspectives of social conduct and 'face-work' (Goffman, 1959) when examining emotional labour.

Central to Hochschild's (1979, 1983) concept is the quality of the face or mask which is presented. Presenting a genuine or 'authentic' (Hochschild, 1983, p.186-98) face to clients and others is regarded as important in attaining the *correct* social interaction, yet some organisations as Erikson and Wharton (1997) explain, require their employees to not only display prescribed emotions, but also to feel them, developing both surface and deep acting abilities through training in order to appear authentic (Fineman, 2000, p.85). However, once again, in doing so, these methods force workers to enter further into 'engagement' with clients and further away from 'detachment' and self protecting.

Provoking theatrical performance to satisfy organisational or group motives and objectives raises the question of how these performances are actually performed. It would be clumsy to assume that all workers prescribe to delivering emotion behaviours in the ways that are expected all of the time. The social actors involved continually and reflexively adjust their performance all of the time, and glide between different performances with fluidity (Goffman, 1959; Bolton, 2001). Not only does diversity of performance exist at the social encounter with patients or clients, but differences in performance exist between what is referred to as 'front stage' and 'back stage' (Goffman, 1959). Existing work of the study of occupations (for example, Carter, 1995; Crawley, 2000, 2004) reveals that behaviours and demeanour alter dependant upon physical environment (for example, 'shop floor', closed office, on a social occasion) and those who the worker is in the company of (for example, patients, prisoners, doctors, co-workers, friends, managers). Often 'front stage' refers to the area which the customer or consumer of the service provided is in direct contact with the worker and professionalism is maintained. 'Back stage' or 'off-stage' are terms

used to describe areas or situations where the organisational prescribed mask is able to be relaxed somewhat, often associated with studies of aberrant medical humour (Selzer, 1976; Robinson, 1988; Goldberg, 1997; Struthers, 1999; Frances, Monahan and Berger, 1999; Sayre, 2001).

Not all performances of emotional responses are possible; despite the workers efforts, all of the time. As Smith (1992) demonstrates in her study of emotional labour in nursing, there are certain mitigations affecting emotional behaviours expressed. The worker's own personality will influence the levels of emotion management, so too will the worker's perceived expectations of what the outcome will be if they act in this particular way. Levels of job satisfaction, opportunities and encouragement in their employment area are all congruent in the conforming, manipulation or resisting of organisational expectations and the success of 'face work' presented by nursing staff. Furthermore, Bolton (2001, p.92) describes a 'detached' face, illustrating the erosion of the prescribed 'face' where feelings of exhaustion, demoralisation, anger and sorrow are overwhelming and the organisational mask slips. Bolton's (2001) research also uncovered a 'hard faced' performance, where feelings of anger and resentment provide an outwardly observable aggressive presentation.

Studies of emotional labour in occupations have highlighted the interrelationship of 'emotion' or 'face' work with occupational stress. Stress, including dramaturgical stress, has been seen to 'impair the social, psychological and physical functioning of an individual' (Crawley, 2004, p.37). Emotion management and the strain of performing correctly and at the correct time in a bid to avoid being seen to not express the organisation's prescribed emotional front has, in various studies being found to directly correlate with levels of workplace stress. Rutter and Fielding (1988), in a study of prison officers revealed that suppressing emotions in order to provide a visibly conforming presentation of correct emotion was positively associated with levels of stress amongst the study sample. In comparison, studies in nursing by Mann and Cowburn (2005) have also positively correlated emotional labouring and workplace stress.

Not only does emotional labouring and the manner in which feelings are displayed impact upon service transactions, but also ‘the way in which emotion is experienced itself’ (Ashforth and Humphrey, 1993, p.88). Internal stresses of performing emotion, as Ashforth and Humphrey (1993) discuss, have a profound effect upon the individual in terms of how they identify themselves. Posing as prescribed by the organisation may well be in opposition to how they see themselves, making it mandatory to negotiate contradictory masks between front and back stage areas. Resistance of such demands in itself is challenging and stressful and workers may feel that their individual identity is being altered beyond control where ‘role-playing has become role-taking’ (Ashforth and Humphrey, 1993, p.102).

Role-taking or being ‘changed by the job’ is also recognisable in Crawley’s (2000; 2004) study of prison officers. In a domain where punitive measures and authoritative language are characteristic of the ‘front-stage’ expression of emotions within prisons, Crawley (2004, p.184) found that emotional labouring in this way led to officers, by their own admissions being ‘changed’ and becoming ‘harder’. In itself, this progression into an identity which has left behind prison workers manageable social identity, and moved towards one which is increasingly desensitised to distress of others and more in line with the philosophy of just deserts punishment and managing emotion to achieve the cultural expectation to be ‘hard’. Crawley (2004) records that one of the reasons officers see themselves evolving into such types of emotional expression, is due to higher levels of transient prisoner populations, where staff encounter higher levels of violence and have less time and opportunity to engage with prisoners.

Workplace Humour

Humour, like other social interaction with staff and clients contributes to the wider exploration of the maintenance of social order in the workplace. Humour may particularly be evident in the relationship status between staff (as both an

authority and caring figure) and the service user. So too may humour play an important part in the enculturation process of staff within occupational teams. Humour may well be considered as an aspect or sentiment of loyalty within a particular occupational group, and forms an important element in the division of conflict and consensus between workers. Humour may also provide workers with a strategy to cope with aspects of social interaction with and a means by which work can be carried out successfully on a personal level.

The potential damage of 'emotional juggling' (Bolton, 2001) to the employee's inner self, in addition to being managed in part by engagement and detachment, is also subject to further occupational influences such as the use of humour in the workplace. Organisational ethnographers have alluded to the importance of humour in everyday workplace practice (see for example, Duncan, 1985, Kuhlman, 1993; Locke, 1997), the general nursing and therapy context (see, for example, Bailey, 1998; Bain, 1997; Bloch, 1987; Ditlow, 1993; du-Pre, 1998; Frances, Monahan and Berger, 1999; Hartman, 1995; Matz and Brown, 1998; Peschel and Peschel, 1986; Robinson, 1988; 1991), in psychiatric settings (see, for example, Buckman, 1994; Alhadeff, 1994; Chung and Corbert, 1998; Erasmus, Poggenpool and Gmeiner, 1998; Fry, 1963; Kaplan and Boyd, 1965; Struthers, 1999), and in studies of prison officers (see, for example, Fleisher, 1988; Carter, 1995; Crawley 2000, 2004). Functions of humour and the use of 'kidology' (Carter, 1995) are defined below in Crawley's ethnography of prison officers:

Humour functions as; a defence mechanism (protecting against emotional stress), a wit sharpener (banter makes you think quicker), a morale raiser (pre-shift 'gee-up' or release of tension when leaving duty), an 'incorporator' (jibes towards new staff to make them 'one of us'), and a strategy for exclusion (e.g. to reinforce that deviant officers are not part of us).

(Crawley, 2004, p.87)

Variations in types of workplace humour also occur. Banter, sarcasm, therapeutic (Ditlow, 1993), joking, whimsical and aberrant (Sayre, 2001) humour typologies have emerged, yet all humour falls within two strands, 'pure' and 'applied' humour (Zijderveld, 1983; Fox, 1990). Pure humour which is

applied for its own sake and applied humour which is produced for a hidden or veiled purpose (Zijderveld, 1983 cited in Crawley, 2004, p.50). Crawley (2004) reveals that for the majority of observations taken place within the prisons, 'applied' humour was the norm; this will be further demonstrated by an understanding of humour as a component of coping strategies of contemporary working.

Unlike 'pure' humour, 'applied' humour is utilised for the purposes of attaining a goal or fulfilment. 'Applied' humour in the context of occupations may well be seen to reside within both front-stage, backstage or offstage performances. Using humour in everyday work practices has been significantly viewed as a coping strategy and used to deal with the social processes of work and the problems that entail within challenging work circumstances (Sayre, 2001); not least by Sigmund Freud (1960) who suggested that humour is the highest possible system of emotional and psychological defence. In managing difficult patient populations and achieving a therapeutic ward milieu humour is witnessed as integral to work performance both in relationships between staff but also in 'client – staff' interactions (Alhadeff, 1994). Managing the work milieu and practical demands effectively can, therefore, help to reduce the personal emotional costs for the worker.

Managing interactions amongst staff groups and management also calls for the ingress of humour into communications. Boundaries between occupational personalities, individuals or teams are often visible through the type, scope or extent of language used. Often, as Goldberg (1997) posits, negotiating these boundaries can be difficult and an ideal opportunity for humour to collaborate within an individual's communication technique or scheme. Often within healthcare, as within other occupations where definitive hierarchical roles exist, communication and interaction between hierarchical groups can be difficult and challenging. Divisions in labour groups such as medical staff and nursing staff often mirror economic or social status, making the division larger and harder to

bridge, yet as social researchers have found, certain types of humour can assist in negotiating hierarchical boundaries.

In her article, Sayre (2001) identifies humour typologies reflecting psychiatric nursing staff's usage and applications. This article supports previous research in the area and what follows is a developed theory of joking behaviours amongst psychiatric hospital staff. To support this understanding that humour and joking are integral within such an occupation as nursing, Sayre (2001) embarks upon direct observation of fifty-nine staff members of a New York psychiatric unit. It emerged that staff used aberrant medical humour widely and consistently during the period of observation.

Developing and linking humour types with levels of emotional expression of nursing staff towards colleagues and patients indicated a broad continuum of hostility towards the joking focus. Divided into two themes of 'whimsical' and 'sarcastic' humour, three sub-categories of joking behaviours exist. Findings indicated that of all of the humour or joking types observed, 58% fell within a sarcasm typology rather than whimsical (40%), with 81% of joking focusing upon patients, 23% of which were classified as malicious in nature. Joking about oneself or colleagues was exclusive in the 'whimsical' theme category, with no evidence of any sarcastic humour directed towards self or colleagues. Despite claims within this study that the highest frequency of joking types were within more severe or malicious types, humour is still cited as being exceptionally useful in; therapeutic client relations, assisting with performing, emotion management and social workplace integration (Crawley, 2004; Struthers, 1999; Bain, 1997).

Social encounters, emotion and impression management have been seen as integral to the workplace environment, both in terms of nursing and prison studies. For psychiatric nursing professionals controlling and maintaining professional demeanours in the face of patient and organisational uncertainty generates a plethora of organisational expectations and individual skill.

Demonstrating a range of types of ‘face work’ within daily social encounters, it may be easy to assume that work is a continual act or performance with a lack of truth or sincerity in their actions. To some degree this may be accurate, as before, nurses have been labelled as accomplished social actors (Smith, 1992). Yet, conversely this performance is not necessarily a false process, but one which holds its values in ‘making social interaction possible and to allow organisations to run smoothly’ (Crawley, 2004, p.45).

Chapter Summary

Little is known about the occupational culture(s) and working lives of mental health nurses. Yet, like prison work, mental health work is characterised by a certain level of pedestrianism coupled with the unpredictable and potentially dangerous character of the job. The problematic nature of caring for a diverse client group in both institutional and less restrictive contexts remains a salient feature of their role (Doyle, 2001) and, like prison officers, mental health nurses have to perform and manage emotion in their everyday work. Workers within hospitals and prisons are obliged to deal on a daily basis with people who are often vilified in the public imagination (Dilulio, 1987) and, in the institutional setting, much of their work can be considered as domestic in nature. As Mason and Mercer (1998, p.2) point out, the values of incarceration are interposed with those of care and compassion within the contemporary institutional mental health setting. At any one time, there may be a dysfunctional balance between the twin concepts of therapy and security. Engaging with, and responding to, these challenges can be observed as an integral component of working life and embedded within normative structures of work. Patterns of work and the social arrangements and relations that contribute to its formation determine the social structure and experience of work life for mental health personnel. In reaction to these demands, it is likely that workers will develop cultural characteristics that reinforce the collective nature of the work.

CHAPTER 4

EXPLORING & RESEARCHING WORKING LIVES

This chapter is divided into the main areas which lead the reader to a clear and comprehensive explanation of the design of the research study. In doing so, each part deals with a particular stage of the research strategy including some reflections on the research experience by the researcher. Firstly, it is the intention to discuss and justify the philosophical, theoretical and methodological issues which inform the actual design of research methods. Secondly, in light of the philosophical and theoretical discussion which precedes it, this part provides a detailed description of the methods adopted in this study. Finally, a reflective and reflexive dimension to the fieldwork phases of this study is discussed, paying particular attention towards; negotiating access and fieldwork experiences and relations.

The research aims and objectives are:

To provide an exploratory analysis of the occupational culture and working lives of in-patient and community mental health workers.

Aims and Objectives:

The broad aim of this study is to provide a sociological understanding of what constitutes mental health work, how mental health work is ‘done’ in an institutional and community setting and the impact of mental health work on those who do it.

- To analyse the nature and social organisation of mental health work within an institutional and community service setting.
- To describe how mental health workers experience specific aspects of their jobs:
 - How socialisation into workplace norms operates
 - How mental health workers feel about their role

- The ways in which mental health workers interpret and apply formal and mandated rules of the job
- How mental health workers perform and manage emotion in their everyday work
- To consider how technological advances and changes in policy and clinical practice affect mental health workers and impact on working practices

Philosophical, Theoretical and Methodological Approach

Discussions in this section are opened by attention to the planning of the research study and by locating the research within the philosophical fields of ontology and epistemology.

Crotty (2007, p.2) suggests that the development of a research study requires consideration of two main questions; (i) what methodologies and methods are to be used and (ii) the decisions involved in justifying the choices involved in using these. Crotty (2007) goes further to state that these two questions are but the start of the journey of choices which inform the origins of the proposal and design.

Philosophical underpinnings, theoretical frameworks and methodological issues remain complex arenas influencing the research preparation. Yet, these are all necessary in order to establish clear linear and grounded direction to the project by the posing of philosophical questions with intellectual authority (Hughes, 1990). Specifically concerned with this study, the researcher shares some limited occupational experience with that of the research subjects. To this end, the researcher has already a number of assumptions of the content of the research and is mandated to negotiate these and manage their influence in the research process. Gray (2004) also agrees that the experiences of the researcher will be complicated by initial questioning of assumptions, but highlights that this is a process which is necessary to the integrity of the work. Gray (2004)

raises the issue that the examination of philosophical, theoretical and methodological frameworks enables the researcher to embed their choices of method within suitably framed and appropriate theories and methodologies.

As the various components and questioning are discussed within this chapter, it is worthwhile to understand that many research methodologists (for example, Gray, 2004; Hughes, 1990; Gomm, 2004) advocate for levels of flexibility in interpretation of philosophical and theoretical frames of reference in order for the study to be successful. The decision making process will be continually justified in the context of this study throughout this chapter, providing the relevant reasoning for the philosophical and theoretical direction attributing to the methods design.

Ontology and Epistemology

The initial philosophical ‘stance’, as Gray (2004) suggests, is influential at every stage of the research design process. To focus upon an ontological and epistemological stance of this study, it is first necessary to provide some definition to the terms. Western philosophy has for centuries been engaged with a constant questioning of our knowledge. The origins of the particular knowledge and the way in which that knowledge is known are the two central questions underpinning the course(s) of action when designing and conducting research inquiry. Hughes (1990, p.5) defines the two positions of questioning as ontology being (i) ‘what kinds of things are there in the world?’ and epistemology which asks (ii) ‘what are to count as facts?’ Put more simplistically, claims of what exists in the world lead to a questioning of how what exists can be made known.

Theoretical Perspectives and Methodology

Social ontological positions, according to Gray (2004) and Bryman (2001), can be considered as constructed of two dominant opposing dimensions of ‘objectivism’ and ‘constructivism’. Objectivism is characterised by the notion that there is an objective reality whereby subjects and phenomena hold an inert

entity rather than subjects, situations and phenomena that are witnessed as social products from a constructivist viewpoint (Bryman, 2001, p.17). It is for these reasons that a constructivist stance is assumed within this study as culture, socialisation, enculturation and acculturation processes necessitate a constructivist approach. Previous research in criminal justice occupations that have unveiled the social realities of such organisations have focused upon the building of meaning associated with interactions and social encounters in the workplace. Research in these areas have proven that various occupational cultures do exist and from this it is not necessary to be objective and begin to question whether cultural systems actually exist or not, rather to gather information on the interpretations and experiences of these.

Qualitative or Quantitative?

Empirical studies exploring occupational cultures have been characterised and dominated by qualitative techniques. Most widely used has been techniques derived from the ethnographic tradition utilising techniques of direct observation and interviewing (for example, Carter, 1995; Herbert, 1998; Crawley, 2000). The use of quantitative methods appears devoid within this area of enquiry, and from the point of view of the researcher, for good reason. What follows here is a justification of the reasons why the qualitative paradigm is engaged in this study of occupational culture.

Bryman (2001, p.20) states that the decisions between qualitative and quantitative approaches are derived from the foundations of the epistemological and ontological perspectives applied. In the case of this research, it has already been discussed how the collection of data based around the identifiable symbols and characteristics of the job are of paramount importance in the construction of individual's experiences and the meanings attached to them. In order to clarify developments of the design of this research, the theoretical perspectives are discussed.

Bryman (2001, p.20) highlights the fundamental differences in qualitative and quantitative research strategies. Quantitative frameworks utilise strong theory

testing and deductive approaches of objectivist ontology. Qualitative research differs considerably and includes approaches that use inductive methods of theory building and generation, emerging from constructivist ontology. One of the main differences between the two strategies is the theoretical perspectives that are used and the differences between natural and social science influences and positions.

‘Standard’ view or ‘natural’ science approaches to inquiry are intimately linked with positivism and quantitative design. Robson (2005, p.20) draws attention to the main tenets of quantitative positivist research. In doing so, he emphasises that this type of theoretical strategy adopts many assumptions that are based upon several areas. The (i) objective knowledge obtainable from science, (ii) strict rules, (iii) measurements and sequences are key to developing universal laws, and (iv) pre-existing hypotheses are tested in order to gain results which can be generalised and set against ‘general’ scientific laws. This empiricist approach to data collection and analysis is usually presented in a numerate manner and, therefore, engages the researcher in the comparing and contrasting of measurement. Typically, according to Robson (2005), objectivist, positivist quantitative investigation is concerned with differences in variables rather than personal views, opinions or reflections of participants.

Whilst many aspects of employee evaluation and audit utilise a quantitative approach (for example, the recording of job satisfaction, recruitment and retention, stress in nursing, support structures), these experiences of nurses may be recorded in isolation and fail in a key area. Many fail to adopt a socio-holistic approach to the social reality, experiences, challenges and situational encounters of contemporary mental health nursing staff, choosing to concentrate on a particular area of interest. Research and audit that have largely consisted of survey methods function to inform on positive and negative measurement of performance, efficiency and staff attitudes in the work environment. These quantitative studies have provided academics, researchers and policy makers with comprehensive measurements of healthcare organisations, and to contribute further in the same quantitative manner to already established data

potentially wastes the opportunity to investigate an area which is so far devoid of research attention. In order to satisfy the need to investigate the holistic social experience of mental health nursing staff, it is necessary to turn the theoretical focus towards one that is constructivist and qualitative in design.

Henwood (1996, p.27) states that 'qualitative methods are privileged, because they are thought to meet a number of reservations concerning the uncritical use of quantification; in particular they address the problem of inappropriately fixing meanings where they are actually variable in relation to contexts'. Here Henwood (1996) draws attention to the possibility of meanings to be lost when participants are confronted with a fixed selection of answers, typical of survey and questionnaire techniques. The rigidity of these approaches is often criticised and qualitative methods described as a favoured alternative when researching complex social arenas. This is precisely one of the main reasons that justify the use of qualitative frameworks in this study. The breadth of data, contexts, experiences and meaning is a salient issue throughout this inquiry, and not to be able to gather data in such a reflexive manner would restrict findings that emerge.

Constructivist researchers are tasked with the 'understanding of the multiple social constructions of meaning and knowledge' (Robson, 2005, p.27). Using mainly interviews and observational techniques (although not exclusively) allows for the collection of multiple participant perspectives through which knowledge is constructed through a subject's experiences in their social world (Crotty, 2007; Robson, 2005; Gray, 2004). Gray (2004) demonstrates that interpretivism is closely affiliated with constructivism and offers an alternative perspective to methodological designs than those used within natural sciences. Within a theoretical perspective of interpretivism, Gray (2004, p.20) defines five examples of interpretivist approaches; symbolic interactionism, phenomenology, realism, hermeneutics and naturalistic inquiry. According to Gomm (2004), phenomenology is the most widely used strand of interpretivism, stating that researchers who undertake such an approach give recognition that phenomenology offers the best framework with which to work within as there is

‘no possibility of ever getting in touch with raw reality’ (Gomm, 2004, p.2), and, therefore, in light of this, it is more important to record how people experience their lives. Similarly, symbolic interactionism is concerned with the subjective meaning attached to particular aspects of an actor’s social life. By revisiting the aims of the research and the data collection technique adopted (oral occupational narrative); the outline design appears grounded within the phenomenological tradition. Polit, Beck and Hungler (2001, p.241-246) state that phenomenology is an approach to ‘thinking about people’s life experiences’ and asking the question ‘what is the essence of the phenomena that people are experiencing?’ Polit *et al* (2001) go further to explain that phenomenologist’s assume that this ‘essence’ can be understood and that critical truths about reality are grounded in peoples’ lived experiences.

Research Methods; Work Life History and Narrative Inquiry

Narrative research differs significantly from its positivist counterpart in its underlying assumptions that there is neither a single, absolute truth in human reality nor one correct reading or interpretation of a text.

(Lieblich, Tuval-Mashiach and Zilber, 1998, p.2)

The above statement highlights the importance of collecting data from individuals in a manner that concentrates upon the significance of data from personal accounts and discounts the notion of gathering and analysing large quantities of data to produce findings that can then be generalised. Narrative researching strives to understand the dimensions of social change via the subjective accounts of those who experience it first hand.

Dex (1991) examines the advantages of this approach, stating that the main contributing factor to sociological analysis that this approach advocates is that by the very design of recording individuals’ narrative accounts provides crucial information of the past in order to gain a broader and clearer understanding of the present. Dex (1991) goes further to explain that, in gathering stories and biographical accounts the analysis benefits from a chronology of people’s lives

as well as the implications and influences of social and institutional structures on their experiences. This is particularly pertinent to this study, as this research strategy will highlight the possible structural factors that impinge upon participants and have moulded or constrained their experiences and actions within their occupational career.

Despite narrative approaches assuming positions of pluralism, relativism, interpretivism and subjectivity, there is still a necessity to construct a coherent and explanatory research method design (Lieblich *et al*, 1998). The design and strategy for fieldwork will be further discussed later within this section of the chapter.

Debate continues of the origins of the narrative technique of qualitative research, with some evidence of the protagonist form adopted by Aristotle. However most noted is the emergence of three approaches in the period between the First and Second World Wars. The Chicago School of sociologists, during the 1930s adopted life story approaches in their investigation of life courses and deviancy (see, for example, Shaw, 1931 '*The Natural History of a Delinquent Career*'), so too, as Miller (2000) writes, the emergence of a growth of narrative inquiry in Western Europe. The significance of social researching during a time of colossal social change, migration, regeneration and poverty in an unstable post and pre-war climate looked towards gaining a record of individuals experiencing these ongoing alterations to their social world.

Today, life history, biographic and narrative approaches to qualitative inquiry is a respected subsection of qualitative research methods. The growth of such strategies of data collection and analysis has gained 'an awareness of the importance of narrative amongst qualitative researchers that has spread through a wide range of substantive areas' (Elliot, 2005, p.5). Developments in narrative approaches have seen significant growth in health care research, gathering and constructing stories of those experiencing ill-health. The experiences of patients in terms of their functioning, illness or disease have been gathered using these

techniques extensively (see for example, Kleinman, 1988; Charmaz, 1991; Kelly and Dickinson, 1997). Elliot (2005) continues to discuss how the utilisation of personal reminiscences and biographical accounts has spread within many areas of sociology, anthropology and sub-disciplines such as criminology. *Figure 1* provides an over-view of the methodology adopted.

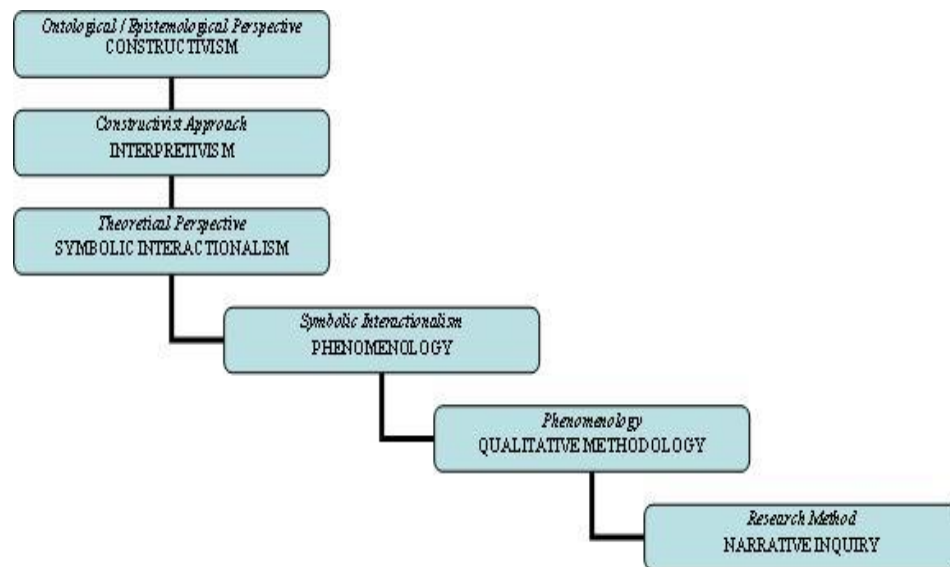


Figure 1 Overview of research methodology and method

The Framework of a Narrative Approach to Data Collection

As is evident from the quotation which opens this section by Lieblich *et al* (1998), there is no one approach to designing and analysing biographical or narrative based data. This is reverberated by many authors engaged in the methodological issues of narrative inquiry and researchers alike.

Polkinghorne (1988) states that narrative inquiry is divided into two distinct categories (i) descriptive and (ii) explanatory. Polkinghorne (1988) suggests that research that falls within a descriptive category approaches the content of dialogue by a thorough description of the narratives already held by the individual or group. The latter category is an approach that aims to explain through narrative why something has happened. It is clear that these categories of narrative inquiry do not exist in isolation, but instead it is likely that the

research proposed here will move fluidly between these two standpoints as it will only be possible to begin to provide an explanation after some description has been collected.

Structuring the approach to fieldwork and analysis has been comprehensively defined by Riessman (1993). Riessman (1993, p.54-60) offers a set of guidance on what she considers as the three main stages of the narrative research process; telling, transcribing and analysis. What follows in this section of the chapter is a description of fieldwork phases that have been designed and are explained in order of Riessman's (1993) framework.

(i) 'Telling' – Fieldwork Interviews and Design

Riessman (1993, p.54-55) considers what are the best approaches to eliciting a narrative based explanation of the participant's experiences. This requires careful consideration of the questions that are asked in the interview stage. Riessman (1993) advocates the use of open-ended questioning techniques that are specifically designed to induce a narrative. Using a single question to elicit a narrative has been further developed comprehensively by Wengraf (2001) within his framework of Biographical Narrative Interpretive Method (BNIM) that utilises a Single Question to Induce Narrative (SQUIN).

The 'BNIM' technique is derived by Wengraf (2001) from the narrative questioning techniques established by Fischer-Rosenthal and Rosenthal (1997). Emerging from a phenomenological tradition, the framework of interviewing that Fischer-Rosenthal and Rosenthal (1997) developed provides a structured research tool that Wengraf (2001) has further develop into a three sub-session, two interview schedule.

Wengraf 's (2001) design of the interview framework (see *figure 2*) consists of an initial interview which uses a SQUIN, a follow-up interview is given after a brief break of at least fifteen minutes. The second part of interview one (sub-

session two) consists of the researcher creating narrative questions based upon the themes that the participant has raised in interview one. Wengraf (2001, p.120) refers to this as ‘returning to narrative’ questioning using ‘Theory Questions aimed at Inducing Narrative’ (TQUIN). The design of these questions is based upon the main themes of the first sub-session, and designed to elicit a greater depth of information regarding the topics that have previously been raised. An important point which Wengraf (2001) notes is that the formulation of these questions should be constructed in the order in which the participant spoke about them so as to avoid possible confusions in the telling of the narrative. Sub-session three takes place on a different session day than the first two. This interview is the opportunity for the researcher to ask questions which have emerged from preliminary analysis of the first two sub-sessions. This interview is more structured and asks the main theory questions of the research that emerge from the aims and objectives of the study protocol. It is common that questions posed here have not been brought up or answered previously, and so this interview provides the researcher with a base of which they have more control of the topics in relation to the main research question.

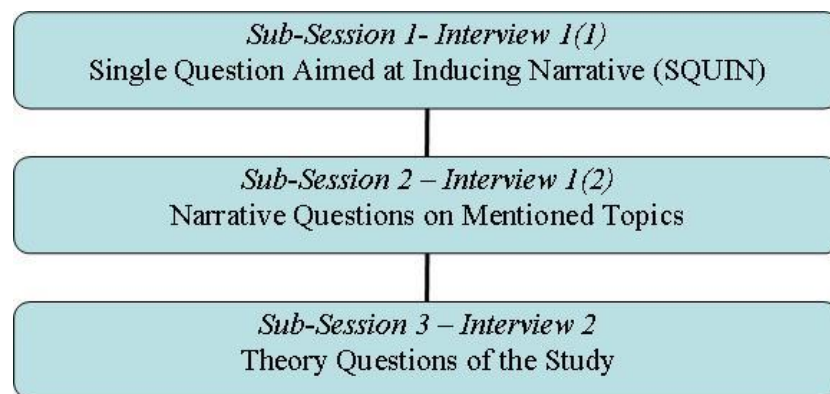


Figure 2. Structure of BNIM interviewing

Wengraf’s (2001) structure of interviewing provides the researcher with a comprehensive framework to be worked within. Full and partial life stories can be collected in this manner, both in terms of providing a chronology to events and experiences of the narrator’s life, but also just as importantly, put forward in a manner which provides some structure and context to the meanings of these

experiences. Both of these important features of the method make this approach appealing to the aims of this research. The non-interference of the researcher in the participant's narration allows for experiences of workers to be collected from their own unique standpoint. In the exploration of cultures within work environments, it is almost certain that some aspects of the workers' interview dialogue when talking of their experiences at work will allude towards relevant sociological theories already informing upon this study. Also, the opportunity to conduct a more structured interview in sub-session three provides the researcher with opportunities to ensure that the main theory questions of the research are being met.

This approach to interviewing participants may appear to be a heavily structured event for interviewees. Additionally, utilising a constructivist epistemology may run a risk of imposing somewhat of a structure upon what may be the totally unstructured reality that participants have experienced. However, focus is placed by the researcher in providing a level of emancipation for the interviewee. Using a SQUIN and a subsequent TQUIN interview, significant control is placed with the participant on how they 'shape' the story and their 'ownership' of the story (Goodley, *et al*, 2004, p.60).

Sub-session One: Single Question aimed at Inducing Narrative (SQUIN)

The 'Biographic Narrative Interpretive Method' (BNIM) is put forward by Wengraf (2001) as a 'rigorous method of narrative interviewing'. Additionally, the BNIM interviewing method, especially the SQUIN interview, provides the participant with the up-most autonomy that is required within a participatory framework. As Wengraf (2001, p.113) states, during the first interview where a SQUIN is used, the researcher must 'give up their control of the interview' and refuse to take up any arising offers of potential control in the interview situation. Power relations within the interview become less sided with the researcher and rest significantly within the camp of the participant.

When structuring the SQUIN question it is the intention, as Wengraf (2001, p.122) states, 'to maintain the principle of deliberate vagueness' to allow for, and requires the participant to, impose their own 'systems of relevance' to their experiences. As this research only wishes to explore the occupational facets of employees, it is necessary to adopt a slightly more restricted SQUIN to obtain a partial biography, rather than a SQUIN that aims to collect narrative based upon a life story. Although the SQUIN is more concentrated, it is still required that it be in the main inexplicit.

Wengraf (2001, p.121-125) provides guidance to those researchers wishing to focus the SQUIN interview either conceptually, thematically or temporally. Here Wengraf (2001) provides an example of how a SQUIN can be directed towards data collection of a particular biographical strand. In the case of this study, the SQUIN has been developed to elicit data of the interviewee's occupational career in mental healthcare. The SQUIN, although directed at occupational years, maintains a non- restrictive structure, and as Wengraf (2001, p.122) insists, 'space for the interviewee to decide how the story starts and ends'. Following the recommendations and the development of an example SQUIN Wengraf (2001) puts forward, the SQUIN for this study is set out below:

I want you to tell me about your professional career in mental healthcare services; maybe you could start by telling me about the time your working life began and became important for you personally, and continue telling how things have developed for you up to now.

Wengraf (2001, p.123) also states that it is important to include the following paragraph into the researcher's question script:

I will listen first, I won't interrupt. Please take the time that you need. I'll just take some notes to use after you've finished telling me about your experiences which have been important to you.

Sub-session Two: Topic Questions aimed at Inducing Narrative (TQUIN)

According to Wengraf (2001, p.119-120), sub-session two is best done on the same day or as soon as possible. In the break following sub-session one, the researcher makes notes on the themes and topics that emerged during the narrator's dialogue of the SQUIN. Sub-session two poses questions on the themes that have been brought up and attempts to gain further clarity and explanation by asking TQUINs in the terms, language and order in which topics were expressed by the participant. Again, in asking questions in the order in which subjects were discussed in the first interview, the interviewee maintains their control in how the story has been initially shaped. Participants benefit from this as power and control of the narrative interviewing remains focused upon the interviewee. Due to an individuals' narrative or experience not being arranged in a linear manner, the respondent is enabled through the interview design, to provide their narrative in their own way.

Sub-session Three: Semi-Structured In-depth Interviews

Sub-session three is a combination of 'preliminary analysis of sub-session one and two, and the main research purposes and theory questions' (Wengraf, 2001, p.120). The questions contained within the final interview are not designed to be narrative inducing, but instead are a set of structured open-ended questions, thus, giving the interview a directional flow. It is not the intention to elicit a 'story' from the interviewee at this stage but rather to maintain the course of the main research questions and aims.

It is at this stage that the researcher deviates from the strict interview framework of BNIM. Wengraf (2001) suggests that sub-session three should be semi-structured based upon gaps that are present from the first two interviews, proposing that sub-session three would differ between participants significantly based upon what they have expressed during sub-session one and two. In order to make some comparative analysis of answers to sub-session three between

participants, the researcher has developed an interview-questioning schedule designed to be applied to all participants of the study. These questions are theme based and ask probing questions related to each area of discussion.

In addition to a flexible interview schedule, time is taken between interviews to make comparisons of emerging themes. This method during preliminary analysis and data collection phases is informed in part by the constant comparative method of linking and generating categories of data (Glaser and Strauss, 1967). Whilst the semi-structured interviewing stage is informed by a BNIM framework, it retains some rigidity in structure across the sample group but at the same time allowing for some degree of flexibility for new themes or issues to emerge during the interview dialogue, to abandon such an idea would position this research outside of the boundaries of phenomenological inquiry.

The questions used in sub-session three have emerged from the theoretical and conceptual issues arising from the review of literature and policy relating to the research area. They have been scrutinised both within the supervision committee and developed further in a pilot study (see *appendix ii*). The interview schedule is divided into six main topic areas:

- Personal Background and Current Occupation
- Nature of the Ward or Department
- Day-to-Day Running of the Ward or Department
- Challenges of the Role and Change
- Staff Support and Social Relations
- Personal Outlook and Reflection

(ii) ‘Transcribing’ – Preliminary Textual Analysis

Riessman (1993, p.56-60) provides detailed experiential advice on the techniques and methods of transcribing audio dialogue. Riessman (1993, p.56) states that there is ‘no easy way’ of completing such a task, but that care should be taken to include as much detail as possible in order to provide a fuller context

to the narrative. Riessman (1993) suggests that an initial 'rough' transcription should be completed and then a 're-transcription'. It is during the 're-transcription' where a textual analysis begins to highlight the segments of narrative.

According to Riessman (1993, p.59), it is also useful at the re-transcription stage to include some indication of the beginning and end of the narrative and organisation within the text. Using Labov's (1972) framework of narrative organisation, Riessman (1993) highlights the use of coding the passages of transcription to show aspects of the narrative. Labov's (1972) model uses five common elements²⁰:

1. An abstract for what follows (A).
2. Orientate the listener (O).
3. Carry the complicated action (CA).
4. Evaluate its meaning (E).
5. Resolve the action (R).

Utilising such approaches as those developed by Schütze (1989; 1992) and Labov (1972) has allowed for greater preparation for the analysis stage of fieldwork. The preliminary analysis during transcribing and re-transcribing allows for a more informed transcription text to be subjected to analysis frameworks later. Additionally, and upon Riessman's (1993) recommendation, audio recordings have been transcribed by the researcher personally and as soon after the interview as to retain as many of the characteristics of the interview as possible.

(iii) 'Analysing'

Data analysis and the methods of conducting this on offer to researchers are vastly broad and can 'easily appear insurmountable' (Crabtree and Miller, 1999, p.177). Content, thematic, narrative and grounded theory approaches to analysis

²⁰ See Riessman (1993, p.59) for an example of the use of Labov's (1972) framework for narrative organization.

all contain within them several possibilities and structured ways of undertaking the interpretation of data. At times, there is little consensus on a particular approach, and debate remains open where one approach may end and another starts (for example, content analysis>thematic analysis, thematic analysis>grounded theory). Within such debates, questions emerge over how categories, themes or theories emerge from the data, and whether the approach is inductive, deductive or a combination of both. So too, concern is raised from the narrative tradition over the extent to which a life story is treated, for example, Fairbairn and Carson (2002) raise warning to the application of heavily structured thematic analyses;

In our view it is regrettable that storytelling as a research method is often viewed merely as a way of gathering data to be manipulated in various ways, which probably involves cutting them up into little labelled specimens – themes and sub-themes – that can be sorted and counted and weighed. There is undoubtedly value, at times, in analysing stories at the level of the concepts or words used. However, to treat stories in this way is to fail to respect the tellers of these stories.

(Fairbairn and Carson, 2002, p.8)

Plummer (1995) draws attention to the possibility that some people's stories may be considered more credible than others. 'Talk from below may be marginalised and excluded, whilst expert talk from above may be given priority and more credibility' (Plummer, 1995, p.29). The researcher therefore has an important part to play in providing the voice to the participant by way of the methods of analysis employed. In a later text, Plummer (2001) describes that the interpretation of narrative can be placed upon a continuum. At one extreme the narrative is used in 'pure' theory construction, with little opportunities for the 'voice' of the narrator to be heard. At the other extreme of Plummer's (2001) continuum is an approach that uses the narrative 'voice' of respondents solely, without any interference of the researcher applying any analysis, editing or interpretation. The approach used here to analyse the contributions of participants lays approximately midway of this continuum. This research presents the narration of occupational stories as provided by the workers

themselves. These narratives are then arranged by the researcher into themes in what Plummer (2001) describes as ‘systematic thematic analysis’.

The analysis of participant interviews in this study has utilised an approach put forward by (Fereday and Muir-Cochrane, 2006). Fereday and Muir-Cochrane (2006) (utilising approaches by Boyatzis, 1998 and Crabtree and Miller, 1999) construct an approach to analysis that integrates both inductive data-based analysis (Boyatzis, 1998) and deductive code templates (Crabtree and Miller, 1999) aligned with tenets of social phenomenology.

Drawing upon the framework of analysis constructed by Fereday and Muir-Cochrane (2006), analysis of transcribed data was undertaken in the following way.

- Stage One: Developing a Code Manual

Within this stage of the analysis process, Fereday and Muir-Cochrane (2006, p.4) describe the use of a code manual to assist in interpretation of text as advocated by Crabtree and Miller (1999). Here an appreciation of the literature which has informed the broad aims and objectives of the study are formulated in an appreciation of the phenomenological position of this study. These themes were drawn from the existing literature (Herbert, 1998) on normative structures of work (law, bureaucratic control, adventure/machismo, safety, competence and morality). This template was prepared prior to commencing data analysis.

- Stage Two: Testing the Reliability of the Code

Fereday and Muir-Cochrane (2006) summarise this stage of the process as a method of observing whether the raw data fits within the code template. In the case of this study, it was possible to utilise three pieces of published literature that all contained narratives of mental health practice (Murphy, 2002; Burrow, 2010a; Burrow, 2010b) and a transcription of the pilot study interview. Opportunity was taken to review the code template by the researcher and supervisor based upon interpretations of the documents.

- Stage Three – Thematic Review

This phase is an initial processing of the information (Fereday and Muir-Cochrane, 2006, p.6). Interview data was again listened to and re-read at this point. Here key themes were generated based upon the content of the narrative. The narratives were read in a manner that acknowledged the whole participant story, rather than strict content analysis of particular segments. *In vivo* terms were recorded in the context of the wider story and key topics of the story drawn from the transcription document.

- Stage Four – Application of the Code Template

Following the identification of themes within the interview transcriptions, they were assigned to the codes developed within the code template (Crabtree and Miller, 1999). MaxQDA software was used to manage the codes and their relationship between text themes. As Fereday and Muir-Cochrane (2006, p.7) recognise also, analysis was ‘guided but not constrained by the preliminary codes’. Furthermore, a flexible approach has been used that supports the ‘co-creation of codes’ (Crabtree and Miller, 1999, p.167). The inductive nature of this approach became clear where additional codes were developed subject to the content of transcriptions. At times these additional codes supplemented those already in place, whilst others provided a developed meaning of an existing code.

- Stage Five – Connecting Codes

Clusters of themes emerged between participants and so codes and sub-codes were developed that provided a code hierarchy that drew together narratives from a range of participants. In turn, further coding took place where differences between themes were evident.

- Stage Six – Legitimising Coded Themes

Through the constant reviewing of data, codes and sub-codes were continually developed and adjusted. Initially, the six codes were; law, bureaucratic control, adventure/machismo, safety, competence and morality. However, based upon the inductive aspect of analysis, these were altered to construct six core codes

of; bureaucratic control, risk management, competence, morality, physical environment and care versus control (see *appendix iii*).

Throughout data analysis, the researcher has remained mindful of the caution that should be maintained to avoid the loss of the participant's voice. Where thematic analysis and coding of interviews have taken place, these have been undertaken with the upmost care and consideration of the story as a whole and has avoided 'the danger of not looking beyond the codes' (Crabtree and Miller, 1999, p.177). It has maintained that an interview narrative is the identity of that person. Indeed, the richness of individual narratives has been retained, whilst simultaneously maintaining a focus on analysis which would observe shared phenomenon within and between groups of actors (Lieblich, *et al*, 1998).

Fieldwork and Fieldwork Relations

Location and Sample

A local National Health Service (NHS) mental health unit was chosen as the focus of this study for a number of reasons. The unit is located in the north of England and offers a wide variety of services to a geographical area encompassing both urban inner city communities and rural inhabitants. Age ranges of service users within the researched areas of this unit stretch from adolescents at age sixteen to the older person aged over sixty-five years.

The in-patient services researched within this study reflect those of most local NHS mental health hospitals. This particular unit comprised of two acute admission wards for adults, one older people's in-patient unit for organic illnesses and a psychiatric intensive care unit (PICU). Additionally, there was a specialist in-patient service for intensive rehabilitation. Each ward and unit is staffed by approximately twenty-five to thirty staff working on a shift basis and a variety of occupational grades. Wards are also supported by an Occupational Therapy (OT) service catering for the needs of service users undergoing assessment or treatment.

Local NHS mental health units provide services for a broad range of clients. At any one time there is a diverse array of service user needs and treatment ranging from informal²¹ service users, day cases (for instance those receiving Electro-Convulsive Therapy ECT), patients detained under the Mental Health Act for assessment or treatment, offenders directed by the courts to receive psychiatric assessment or treatment and those mentally disordered offenders restricted by the Home Office to reside in hospital. The management package of such a local unit is engaged in a constant policy and practice challenge of delivering and integrating security, control, treatment and care at varying degrees. Where staff come into contact with such diverse service user groups, and the measures and treatments involved in providing a service for them, it is envisaged that staff working there will have a plethora of knowledge, skills, expertise and experience that is unique to this particular discipline of nursing and care. For those working within this local unit, they are not necessarily engaged in the care of one particular client type or group (for example, adolescents or forensic service users) but are required to work fluidly between extremes of security/control, age, diagnosis, treatments and other associated characteristics. In doing so, findings may be reflective of other mental health workers.

The study sought to recruit members of the nursing and wider allied care team in the following areas:

- 2 x Acute admission wards for adults and functionally ill older people
- 1 x Organic Older People's Ward
- 1 x Psychiatric Intensive Care Unit (PICU)
- 1 x Intensive Rehabilitation Ward
- 1 x Occupational Therapy Department (In-Patient Services)

Those occupational groups invited to participate were:

- Modern Matrons
- Ward Managers and Team Leaders

²¹ Informal referred to in the context of the Mental Health Act (2007) and therefore not subject to restriction.

- Senior Staff Nurses and Staff Nurses
- Specialist Community Nurse Practitioners
- Healthcare Assistants / Clinical Support Workers / Ward Housekeepers
- Domestic and Support Team Assistants
- Occupational Therapists and Technical Instructors
- Bank Staff
- Ward / Department Administrators and Clerks

Those excluded from the study were:

- Service Users/Patients/Clients
- Medical Staff including; House Officers, Senior House Officers, Registrars, Consultants
- Pharmacy Staff
- Porters and Catering Staff
- Student Nurses and Medical Students

To provide an alternative dimension to the study, recruitment within a Crisis Resolution Home Treatment (CRHT) team was sought. Staff who work within such a community team are tasked with the assessment and treatment of individuals who in previous years may have required hospitalisation. Supporting early hospital discharges, bed management, offers of alternative to hospital and is representative of a team that aims to reduce levels of hospitalisation and promote management of recovery in the home environment. This is done via close inter-disciplinary working between in-patient services and community services. The close working relationship of the CRHT teams and in-patient wards makes CRHT an appealing population to provide comparison to the in-patient perspective. Whilst experiencing their own occupational social world, their closeness to in-patient wards provides them with an insight of social realities within the hospital setting and, thus, it may be possible that comparisons may be recognised by those working in the community.

Negotiating Access, Ethics and Recruitment

The success of any research study is dependent upon good access.

(Smith, 1997, p.273)

Researching within a large public sector organisation can be challenging. Furthermore, researching within a spatially restricted environment (for example, a hospital) can present additional obstacles in conducting empirical inquiry. This section of the thesis documents some of the personal experiences of the researcher in negotiating access to the field and the ongoing reflexive approach adopted by the researcher himself.

Above all, the researcher, on reflection, has made a success of data collection through continual flexibility, resourcefulness and a general method of adaptation based upon specific encounters. In addition, particular personal attributes can be observed that both help and hinder in the fieldwork stages of this research, for example, the researcher's own occupational background, academic background and self presentation²². These attributes have been utilised with a great deal of skill by the researcher (although some have had limited success), most notably where meetings and encounters between researcher and organisational and knowledge gate-keepers has taken place.

The period of growth and organisational change within the NHS and the research site (see Chapter 4) at the time of this study has too thrown up, on reflection, some interesting observations in the process of planning and collecting data. Suspicions over the motives of the researcher have been apparent at times and at all levels of access negotiation, but has been manoeuvred around by the researcher being conscious of the impression which he makes through all mediums of communication (face-to-face, telephone, letter and email). In most cases, the researcher chose to adopt face-to-face contact as a

²² See Goffman, (1959) for an overview of dramaturgical presentation of self

principle tactic as this was considered the best approach in order to build levels of trust between the researcher, access gatekeepers and the researched.

In gaining access to the research sample (front-line workers), several access gatekeepers were encountered. Early in the planning stages, the researcher met with the bureaucratic function of the NHS local research ethics committee (LREC). Initial plans had been to gather data using methods of direct observation within the wards and the community team. However, following lengthy applications (some 60 pages) and a personal presentation to the ethics committee, this was rejected based upon 'unsatisfactory data collection methods'. The ordeal which the researcher found himself in during this process was extremely interesting.

On the day of the proposal hearing, the researcher made himself available for any questions from the panel (around twenty members). This panel was a variety of health professionals and lay members, although there was no representation of mental health nursing staff or allied therapies. The majority of members were surgeons, physicians, medical academics and members of the clergy. The same committee deliberated all research applications for the local area including national drug trials, and so, following informal conversations with other applicants, the researcher found his socially scientific qualitative study nestled amongst a series of quantitative drug trials.

In the meeting, the researcher was asked to give a verbal précis of the project and then respond to questions. A range of questions were asked from all directions of the room and visible arguments and disagreements emerged between members of the committee on particular issues. One member asked:

On your application form, your review of the literature talks about the 'cop-canteen' culture. Does this mean that you will sit in the staff canteen and observe the staff?

Questions such as this frustrated the researcher, as it was evident that members of the committee had not digested the protocols in any great detail. Also, the

questions moved beyond the ethical dimensions of the study and indicated an arousal of suspicions on the motives of the study:

Q: How are you funding your research?

A: I am self-funding sir.

Q: Arh, yes I see that from your application. Can you afford to conduct this work on your own or is someone else paying for it?

A: I can assure you sir that I am funding this entirely from my own pocket; there are no other organisations or individuals involved in financially supporting this research.

Despite the researcher attempting to defend his project and the ethical issues involved, the committee were not happy that detained patients would be able to provide informed consent for the researcher to be present in the clinical areas (perhaps an indication of the under-representation of psychiatric practitioners at the meeting).

A great deal of time was then spent in deciding how the data could be collected and the cultural aspects of work captured. Almost all studies of public service occupations (for example, Police, Prisons and Fire Service) have involved some level of observation. Deliberation over alternative methods resulted in a protocol being formulated using oral histories and narratives as the key method of data collection. Interviewing of staff would take place outside of clinical areas, thus avoiding the consent issues raised by the LREC. Resubmission of the revised protocol and negotiation with the NHS Trust research department resulted in approved access for the period September 2008 to September 2009 (see *appendix iv*). Furthermore, a participant information sheet (see *appendix v*) and consent form (see *appendix vi*) were developed in accordance with NHS research governance guidelines.

Despite approval from the Trust's research department and research manager, local access had to be negotiated. *Figure 3* illustrates the extent to which the researcher had to gain the approval through the hierarchical structure of hospital management. Each individual or stage had the capacity to deny access to the particular staff group(s). Negotiating access within such a hierarchy required

different and unique approaches at each stage in order to gain trust and acceptance in the field.

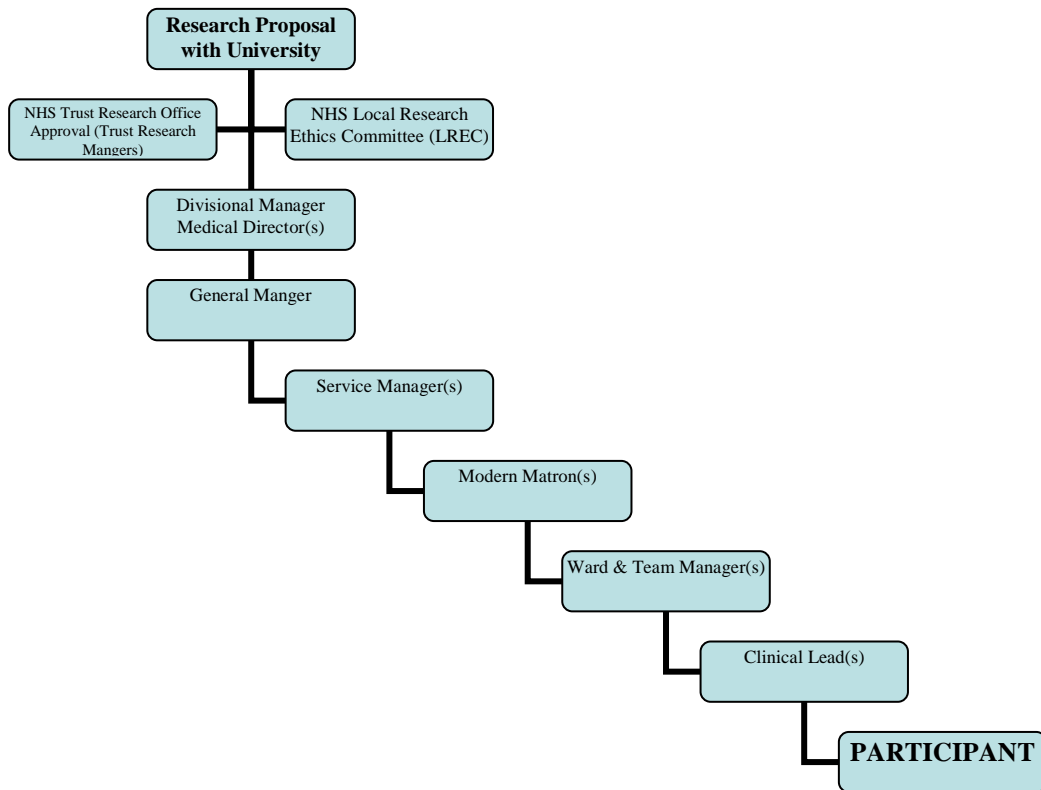


Figure 3. Hierarchy of access gate-keepers

The first port-of-call for the researcher was the organisation's top echelons of management. Divisional managers and medical directors were thoroughly briefed on the intentions of the researcher and the content of the proposals. It was anticipated that through their approval, subordinate managers would be more endearing of the research and provide few obstacles. A presentation to the Divisional Management Board was completed with the support of the research supervisor. Comments received were positive, quite a contrast to those experienced up to this time from senior NHS figures. Approval from this board was perhaps just the beginning of the process by which the researcher managed his own outward image and impression. Gaining the cooperation and agreement

of another five layers of gatekeepers was then necessary before any contact could be made with participants.

- **Gaining Trust, Being Accepted & Influencing Gatekeepers.**

As has been mentioned earlier, the biography and outward impression (for example, trust building) of the researcher has been crucial to the success of gaining acceptance by organisational gatekeepers (managers) and knowledge gatekeepers (participants). Importantly, the challenge of researching within the confines of a 'total institution' (Goffman, 2007), made it necessary for the researcher to gain some institutional acceptance (Carter, 1995). Institutional acceptance would be achieved through the sharing of occupational commitments and the previous occupational socialisation of the researcher within the psychiatric hospital environment.

- *Biography*

A main concern that was raised though the navigation of gatekeepers was the potential for the study to interfere or disrupt normal work practices. Here, the researcher could adopt previous occupational experience in mental health services to appease any concerns. A manager commented:

You know, this is a busy place to be. The staff are run off their feet and you may be disappointed if you arrange to interview staff and things happen on the ward. When the staff are needed, they are needed.

(Anonymous Ward Manager)

The researcher replied with:

You shouldn't be concerned. My experience in such a job for over a decade tells me of the daily challenges your staff face. I am under no illusions that interview arrangements may be cancelled at short notice. I understand that the best made plans can go to waste in an environment like this. This study will be completed with the least disruption as possible.

Whilst concern may be raised over the objectivity of a researcher, this potential bias was quickly acknowledged, and through personal reflection and reflexivity at all stages of this study, the researcher has attempted to present this study without prejudice and with balance. For the purposes of negotiating gatekeepers for access and the recruitment of participants to the study, it is believed that the biography of the researcher has helped in the breaking down of barriers that could have potentially occurred between practitioners and academic outsiders or intruders.

The process of gaining trust from various members of the management structure allowed for the researcher to progress to the next subordinate in the hierarchical structure, eventually reaching the frontline worker (participant). Acting in a respectful manner and being sensitive and sincere with the challenges faced by those involved in the research are all attributes already instilled in the researcher through his experience of working in the health sector. Yet, the previous socialisation of the researcher into occupational norms of such an occupation presented a challenge particularly whilst interviewing participants.

To avoid personal interference in the interpretation of dialogue and narratives presented, the researcher had to feign an appropriate impartial image to participants. Despite the researcher relying on their occupational biography to navigate the access and recruitment issues, rich data could only be conveyed during interviews if the researcher professed to know nothing of participant's daily work. To allow for the participant to believe that there is some level of assumed knowledge on the part of the researcher could potentially threaten the quality of the dialogue in the interviews. This was tackled by a flexible approach in the interviewer-interviewee relationship. Full explanations of experiences were advocated 'for the purposes of the tape' and whilst an occupational commonality existed, it was made explicit that items brought up in interviews should be expressed without any level of assumed knowledge.

- *You scratch my back.....*

Whilst the independence of the researcher was made explicit from the beginning of fieldwork relations, the researcher remained conscious of not only the personal benefits of the study, but also some of the ways in which the research site would benefit from the work completed. It has always been the intention that through the independent nature of this study, that the worker's view would be given an academic platform from which challenges of their job were made clearer to a wider domain. Also, findings from this study may also go some way in informing strategic direction of the organisation. This was made evident at the initial meeting with the NHS Trust's Divisional Management Board, where the Chair stated:

Coming from an independent perspective allows you to gain a greater insight into the lives of the employees themselves, much better than we [managers] could possibly do. I will be passing the details of your study onto the Director of HR as I think they will be very interested in what you will find.

(Chair, Divisional Management Board)

Such a statement made it much clearer to the researcher of the possibility of suspicion amongst potential participants. Much effort was put into ensuring that an independent impression was made to potential respondents. Participants would know already that to be allowed to interview them would have meant that the researcher has already met with Trust senior management, and the suspicion that the researcher was 'in the managers' pockets' was very real. A staff member who decided against participating commented:

How do I know that you won't misconstrue what you find out? Not that I have done anything bad or wrong, but you may mis-interpret something I say as something as being against the rules.

(Anonymous Staff Member)

It is without doubt that approval for access by hospital managers was made easier by the potential benefits that the study may hold for them. This is perhaps

one of the great challenges of researchers entering into someone else's domain to collect data. Ownership of the work must be maintained through careful negotiation and clear explanations to key gate-keeping figures. When the researcher meets with participants, then their principle task is to placate any anxieties of managerial stakeholder-ship in the project by being flexible, transparent and responsible.

- *Getting people on-board*

Recruitment to this study utilised a 'snowball' sampling technique through advertisement, invitation and word of mouth between healthcare staff (see *appendix vii*). The majority of the twenty participants who engaged in the interviewing stated that they have done so because they were enthusiastic about telling their side of the story. On numerous occasions, nursing and allied staff have been portrayed in a negative manner in the public domain (see, for example, Patient's Association report 2009). Staff felt that they could perhaps go some way to redress this imbalance by participating and also 'get things off their chest'. Crawley (2004) also encountered a similar situation:

[T]he majority of officers I approached were extremely keen to talk about their work. Indeed all of my interviewees claimed that our discussions represented the first real opportunity to speak at length about their working lives to someone who seemed genuinely interested in understanding prison life from their perspective.

(Crawley, 2004, p.64)

Nursing and therapy staff who expressed an interest in participating in some instances commented that they had put their name forward because they had spoken to others who had already taken part. The benefits which participants were obviously gaining were similar to those expressed by respondents to Crawley's (2004) study. One participant remarked at the end of an interview:

You know what Paul, I really enjoyed that. It was like clinical supervision but without having to hold back. I feel like I have had a good old rant.... I feel much better now.

(Staff Nurse Hoy; Thames Acute Ward)

Another commented:

Its funny, I've worked here for God knows how many years, and you just don't get the chance to think about all the good old days. I never thought that I had so many fond memories of work 'til I sat down and started talking to you.

(Occupational Therapist Burton; Avon Occupational Therapy Service)

It had always been the intention of the researcher to plan and design the study in a way in which participants actively engaged and benefited from taking part. The quotations above clearly show some of the benefits of this approach with this particular sample in providing an additional opportunity for 'pit-head time'²³. Goodley *et al* (2004, p.60) gave strength to the narrative method in suggesting that 'a key element of this approach is the idea of emancipation, doing the research ethically so the interviewee might usefully gain something from the production'.

Pilot Study

A sensitising pilot study was performed prior to the main phase of data collection. This enabled the utility of the interviewing schedule to be examined and also the content of the interview questions. It assisted in deciding which 'questions should be asked and the structure that they should follow' (Henn, Weinstein and Foard, 2009, p.324). In addition to this, the utility of the code manual (Crabtree and Miller, 1999) for analysis was evaluated.

The pilot phase of this study also provided further insight into the power dynamic between interviewer and interviewee. As has been mentioned earlier in this chapter, the approach undertaken here aims to provide the interviewee with as much control over their narratives as possible. The pilot study also proves

²³ Pit-Head Time refers successful changes in work regulations for miners in the 1920s. Miners were allowed to clean themselves of the coal dust within the hours of the working day, rather than in their own time. Timpson (1996) draws reference to this in nursing care in stating that healthcare staff should have adequate opportunity within their working day to deal with the emotional dimensions of their work.

valuable in assessing how much control the researcher has in the interview process (Somekh and Lewin, 2005).

Chapter Summary

Collecting employee narratives and occupational life stories will complement existing bodies of knowledge and analyses of mental health work. Adopting a methodology emerging from the narrative tradition, findings will afford the academic domain and policy planners with rich and context-based insights into the occupational challenges of contemporary working.

The thoughts, feelings and opinions of those participants involved are prioritised through the techniques adopted at all stages of this study. In addition to this, the methods and methodology focus upon techniques that are aggregated in providing an empowering and emancipatory experience for workers involved. A further method of preserving the voice and background of those participating can be found in *appendix viii*. Readers of this thesis are encouraged to use these summary impressions as an additional resource in the reading of participant narratives.

The following chapters present the findings and core theory of this study. Six normative orders of mental health work that pertain to the institutional and community contexts of modern psychiatry are offered in chapters 5, 6 and 7 with a detailed rationale for this approach in chapter 8.

CHAPTER 5

PLAYING BY THE RULES; BUREAUCRATIC CONTROL & RISK MANAGEMENT AT WORK

I sometimes wonder how far policy will come in front of our work. Sometime you feel that your hands are tied behind your back. There is a constant undertone of needing to be efficient.

(Technical Instructor Pervis; Avon Occupational Therapy Service)

The findings of this study represent a multitude of complex issues facing mental health workers in today's changing climate of modern psychiatry. Evidence collected from participant narratives indicate that there are several components which all of those, and to a large extent, other individuals working in the mental health field, will come into contact on an everyday basis. Technical Instructor Pervis highlights above one such component, efficiency and how this is inextricable linked to all aspects of work.

Chapters are divided, each deliberating and discussing two closely related normative orders of clinical practice (as developed from Herbert's (1998) normative order of policing – see Chapter 3). Firstly bureaucratic control and risk management are discussed, followed by competence and morality, and finally physical environment and care versus control.

The NHS, like most other public and private organisations are subject to strict levels of governance, control and accountability from central government, governing bodies and management boards. Stakeholder consultation, along with research and economic imperatives, is at the forefront of developments in the United Kingdom's health system. The process by which development and change occurs is often the result of cascaded guidance from Parliament as directed by bodies such as the National Institute for Clinical Excellence (NICE), the Department of Health (DoH) and Royal Colleges (for example, Royal

College of Physicians, Royal College of Psychiatrists, etc.) to name but a few.

Increasingly, local NHS Trusts are developing their own organisations, particularly economically, in the attainment of Foundation Trust status. Fulfilling the criteria of Foundation Trust status enables local NHS Trusts to have a greater share in the decision making, spending and service provision for their particular local area. Additionally, there is focus on the 'sale' of specialised or specific services to other health providers in order to reinvest capital into local services.

As with other organisations, large and small, quality of services is of paramount importance. This has, perhaps, led its own way to the forefront of the health service agendas, not least for the potential inflammatory publicity or possible litigation cases put forward (see Chapter 1). Clinical governance and risk management has grown significantly in recent years, and the NHS as a whole has embarked upon developments in the future of risk, litigation and quality, represented, in part, by the commissioning of the NHS Litigation Authority (NHSLA) and the work of NICE.

Systems of organisational and professional control or governance are complex and multidimensional. White Papers, Green Papers, Parliamentary Bills, Legislation, Pay Agendas, Service Frameworks are but a few documents at the heart of modernisation and development of health services emerging centrally. Simultaneously, local policies, service redesigns, local pilot studies and Foundation Trust status leave workers within these organisations with a challenging system to negotiate on a daily basis. Whilst much time and money is spent in defining the strategic direction of services for the public, working within this system of control, governance and risk management raises significant issues in how best 'shop-floor' workers can incorporate these within their daily role set. Narratives presented in this study illuminate upon the possibilities for a disjuncture to emerge in daily practice between incorporating significant policy changes into existing (and somewhat traditional) roles.

Low job satisfaction and staff burnout are experienced by nursing and therapy staff due to dramatic and sustained modernisation of health services. Such reasons need to be researched in relation to the context of daily practices and clinical roles to gain further insight into this situation. This chapter identifies areas of conflict and consensus associated with bureaucratic control and risk management measures as part of the larger exploration of mental health work developed in the remainder of this thesis.

This chapter analyses how mental health workers experience regulation in their jobs and how such regulation imposes potential conflict between the workers and hierarchy alongside the potential for consensus. Although both bureaucratic control and risk management are considered within this thesis as components of a normative order of mental health work (systems of rules, obligations or shared value commitments governing the role that attempt to maintain social order), the issues raised by respondents are illustrative of how the social order of mental health work may be jeopardised due to the pressures and challenges workers face by external influences (for example, policy makers, politicians).

There are two main aims within this chapter:

- To analyse what elements of bureaucratic regulation and risk management are interwoven into mental health workers' role set.
- To analyse how workers interpret and apply bureaucratic regulation and risk management strategies in their work and the effects of this on occupational life.

Part One: Bureaucratic Control & Regulation

In this section, explanations of the influence of bureaucracy on daily work are presented by a range of employees. Staff nurses Hoy, Dignan, Peterley, Thomas, Weaver and Rumsey offer an illumination of the impact of bureaucratic regulation in their practice within the acute admission ward environment. Further, Staff Nurse Tonry discusses the effects within the in-patient rehabilitation setting. Community Specialist Practitioners Chapman, Hunt and

Watts provide a contrast to those working within in-patient environments, and also Occupational Therapist Gannon and Technical Instructor Pervis draw attention towards the integration of systems of governance within the occupational therapy context.

Much attention has been paid to the operational and symbolic mechanisms of a contemporary bureaucratic organisation. Within this, the utility of such organisational measures of bureaucracy have been examined, with some authors and researchers suggesting that within the National Health Service (NHS), 'bureaucracy is both useful and durable because it means that governments can rely upon the obedience of bureaucrats' (Scofield, 2001, p.77). Conformity to organisational goals amongst occupational groups is of particular concern for modern managers and executives. The overall public picture of the organisation is crucial to their future, none more so than public organisations financially supported by the tax-payer.

Scofield (2001) claims that the public sector worker within the bureaucratic organisation are in a paradoxical position. Workers are positioned as a bureaucrat within a bureaucratic structure, but they themselves feel a genuine responsibility to the public as their payments are made through the public purse. The disjuncture of this situation is that workers often find themselves located in a position where they may feel that they are being irresponsible towards the public on a personal level, but are restricted into the boundaries of obedience set by the organisational rules.

Conflict between the bureaucratic functions of various NHS administrations has emerged also, not least through devolution (Adams and Robinson, 2002) but also through de-centralised economic governance (for example, Foundation Trusts). In light of this, public policies on health will vary considerably, and so-called 'post-code lotteries' of services have attracted particular attention. The NHS workers as a representative and subordinate of this may well feel aggrieved or confused of their own moral position within this. Again, and on a broader scale, this represents a condition where workers have to adjudicate

between formal rules of their work and the informal norms or strategies which are adopted in order to maintain work imperatives or gain personal approval and satisfaction.

NHS Trusts are becoming increasingly subordinated to central bureaucratic organisations such as the Department of Health (DoH) (see *appendix x*). Trusts themselves are also becoming more aligned as bureaucratic organisations. Contemporary NHS Trusts are tasked with enacting key measures dictated by central health bureaucracy (for example, Department of Health, National Institute for Clinical Excellence), but also in consultation with key central documents, must create and develop policies themselves. Economically, Foundation Trusts are representative of decentralised economic bureaucratic controls; however, many of the key areas of health and social care policy remain super-ordinated by government offices.

The interaction of bureaucratic and managerial interventions within the care field can be demanding to contend with. They range in their magnitude, but none-the-less become embedded in all employees' work and practice. Staff Nurse Tonry describes from his perspective:

[When I was a Support Worker] I liked the work at the Crisis Team, it was changing everyday, for example, new protocols sent down from up above. There was something new happening everyday. I think the issues of change were a burden on the trained staff because they were having to deal with the bulk of it all, but as a support worker you aren't that involved, your more client led more than the trained staff were. They had to face all that change and regulation from them up above. It was a challenge to them; it really was, you could see it. It took its toll on a few of them to be fair.

(Staff Nurse Tonry; Trent Intensive Rehabilitation Ward)

Professions, as well as users of a service (for example, patients), have long been regulated via a hierarchical structure. Accounts of early influential figures in the psychiatric movement include John Monroe, who, in eighteenth century Britain and with close links to the gentry, plied his trade in 'mad-doctoring' (Andrews

and Scull, 2001). Again, the emergence of psychiatrists and treatment of the insane enabled many eighteenth and nineteenth century medical professionals an opportunity to align themselves amongst the middle and upper social classes. With this came power, and the ability to commit individuals to large county and city asylums such as Bethlem hospital for treatment. Psychiatrists became the kingpin of the treatment of so-called dangerous classes (for example, paupers and lunatics), and also as distinctive leaders of the organisation and administration of treatment within asylums for the insane.

Psychiatric nursing too evolved. As the number of county asylums grew, and the reform movement gathered momentum²⁴, psychiatric nursing expanded to provide care, treatment and, for some, incarceration, of the growing insane asylum population. Traditional hierarchical structures have been maintained within the medical professions (most notably influenced by the legacy of high numbers of ex-military personnel working in psychiatry following WW1 and WW2) and the differentiation between doctors and nurses resonating from underlying issues of sex, social class inequalities and access to education.

This is not to say that contemporary mental health care is unrecognisable with its past. On the contrary, although there have been significant developments in occupational inequalities, and a growth in the autonomy of nursing staff, doctors remain, in the clinical domain, higher up the health system hierarchy than nursing staff. Looking towards the operational management of services, this has perhaps been the site of most change over the history of psychiatric provision and the development of the NHS. Memberships of senior management boards have become more and more diverse. Medical and senior nursing staff who once occupied the majority of positions are now complimented by individuals and professionals with experience from outside of the public service health sector. Strategic management is often influenced by ‘external’ business knowledge from professionals with experience outside of statutory health providers. This eclectic combination of management skills is widely thought to hold the key to

²⁴ French reformist Phillipe Pinel led a movement towards care and treatment of the insane rather than punishment and incarceration during the late eighteenth century and early nineteenth century (Rogers and Pilgrim, 2005).

the future of the NHS, but at the same time, is potentially unrecognisable to the historical and traditional systems of regulation and hierarchy within mental health care.

‘You don’t just chase paperwork, it chases you!’; Policy Sanctions in Mental Health Work

Bureaucratic regulations within organisations constitute guidelines for acceptable behaviours (Herbert, 1998, p.354). In doing so, they also provide ‘legitimate power’ to managers to dictate to their subordinates how work is to be performed (Trice, 1993, p.151). In addition to the basic altruistic principles of nursing care, bureaucratic regulations further define the social and spatial world of concern for workers (Herbert, 1998). Sanctions and regulations within the organisation centre on two main issues; policy governance and hierarchy. The two are closely affiliated as often various members of the organisation’s hierarchical management system are responsible for the development and dissemination of policy initiatives. Workers on the ‘shop-floor’ of the occupation are then tasked with inserting the often complicated and challenging elements of policy into daily practice. For some workers involved in this study, the process by which policy decisions cascade is further representative of power imbalances between workers and managers.

For every scenario there is a policy, if something happens the first thing you do is get the policy manual out and do a,b,c and d. You get no respect for your experience or knowledge of the clients, its all policy policy, policy, that’s what frustrates me. I like to think that I have enough experience to do my job with my eyes shut.....

When there is trouble you see them [management] peering over the rafters seeing who to shoot.

(Staff Nurse Hoy; Thames Acute Ward)

What I would like to see is management being more aware of the reality of what goes on the wards and at grassroots level. To be honest, I don’t think that they really want to know what is going on, which is a problematic situation.

(Staff Nurse Dignan; Humber Acute Ward)

For Fineman (2000), power imbalances and hierarchical struggles in the workplace are of serious concern. The division and distribution of power in comparison to the worker's position within the 'bureaucratic flowchart' of the organisation (Herbert, 1998), can potentially 'cause a reluctance for workers to reveal their occupational pains' to management (Fineman, 2000, p.34). Concerns over the consequences of discussing possible inflammatory issues with line management may well, as Fineman (2000) discusses, raise a fear that by asserting a worker's individual issues may potentially jeopardise their position within the organisation, further enhancing a powerless position. Clinical, managerial and peer supervision goes some way in attempting to reconcile this potential problem (opportunities for pit-head time). Staff can choose a member of staff within their organisation that they feel comfortable in discussing issues with, however, at certain points within a worker's career, the necessity to raise issues with line management may occur, questioning, challenging or reinforcing power relations within a team of staff.

Bureaucratic control and power relations between 'shop floor' ward staff and management are perhaps made clearer in the narrative account of Staff Nurse Hoy, a male staff nurse on an acute admission ward:

This team is the best team I ever worked in, 'cos we have a good mix of experience and youth. There are newly qualified staff who know stuff I have never learnt. It is a good blend, but is hard when morale is so low with the threat of wards closing down and new ones opening. Nobody knows where they are really. What really grieves me about the job is that nowadays your experience counts for nothing, because everything is done by policy. Whatever happens there is a policy for it, that's what is frustrating. A few years ago if you had say a missing person, it was your judgement on whether to involve the police or not because you know they will be at home or in the pub and come back. Nowadays if someone is detained, you do the missing persons; ring the police regardless of whether you as a nurse think they will be back after an hour. We had 3 people go missing one afternoon and a senior colleague telephoned the senior manager explaining that we were 90% sure they would return together, but the response was that the policy speaks for itself. It just seems that a robot could do this job. It seems that the job is an automated thing, but we are dealing with people. It's not a black and white job, for me that is general nursing. There is no leeway or bending the rules, it's all dictated to you. But that's the way it's gone and there

isn't anything I can do about it. When I've done the job for as long as I have I think we should have more autonomy over our decisions.

I look for jobs every now and then, but I never apply. I will probably be here when I'm 60 because I enjoy the ward environment and working as a team. I've never aspire for promotion, but although I have had opportunities, I trained to be a nurse and the higher up the ladder you go, the less nursing you do. I didn't train to go to meetings all day, I trained to nurse people.

If someone gets hurt in a C&R [care and responsibility/control and restraint] incident in Essex for example, every hospital thinks 'Oh we better cover ourselves and draw up a policy for that'. It drives me mad it's a people job, it's gone very impersonal. It's good for newly qualified staff, but I have the experience to deal with situations. It's gone for me from one extreme to another in the private sector where things were out of my control to situations that I could perfectly control but I'm not allowed to. I think sometimes this is worse than going into a situation where you know nothing, because you would deal with it as best as you can. Having the knowledge but not being allowed to use it is more frustrating than not having the knowledge in the first place.

(Staff Nurse Hoy; Thames Acute Ward)

Staff Nurse Hoy clearly states how the mechanisms of policy and regulation are restricting him in the application of his 'craft' of nursing, removing his experiential autonomy, and succumbing to strict regulation of his clinical practice and more importantly, regulation of the skill set of him as a nurse. Without feelings of freedom and autonomy, the danger presents itself of a movement away from power, and more towards occupational powerlessness. Education as a pre-requisite to qualified nurse status, and later experiential knowledge, allows for mobility within the hierarchical structure of the organisation. Yet, as Staff Nurse Hoy suggests, the role is becoming more 'robotic'. Therefore, mobility becomes impeded where autonomy and power are diluted by regulation and organisational sanctions. Indeed, the worker succumbs to a position of limited power within the bureaucratic structure. A delineated hierarchy remains a powerful component of occupational life. This is structured by a pyramid of bureaucracy (see *figure 4* below) where-by senior roles within the organisation manage the bureaucratic functioning, maintaining their powerful position by instructing subordinates of the organisation.

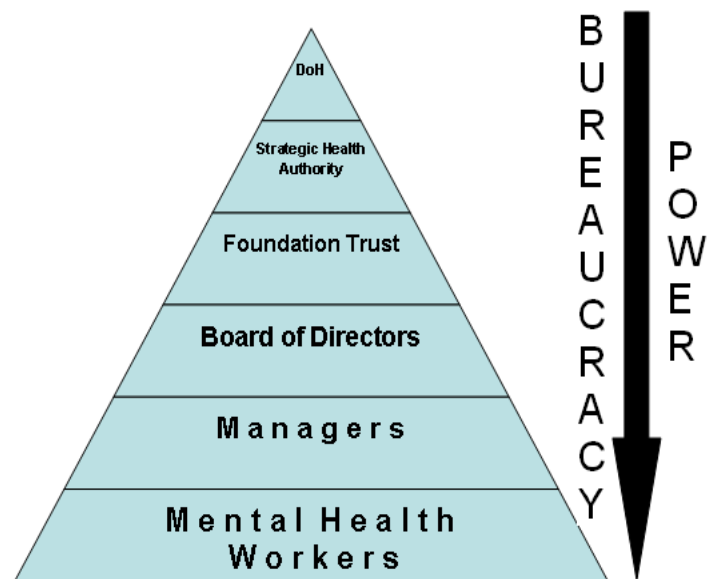


Figure 4. Pyramid of governance

Political and legislative developments are also prolific within the context of contemporary work. Particular White Papers (for example, NHS Plan, 2000), proposed Bills and Bills receiving Crown assent (Acts), have become synonymous with major changes in clinical practice and organisational structure. Radical shifts in the philosophy of caring for the mentally ill have developed in the UK predominantly in the latter part of the twentieth century.

In the collection of oral histories of work, those who have worked through the 1980s and 1990s experienced first-hand one of the most provocative changes in their work. County asylums in England and Wales had been gradually declining in their occupancy from the nineteen sixties onwards through recommendations contained in the Hospital Plan (1962). Scull (1984) puts forward a bi-dimensional perspective on why this was the case; the development of licensed antipsychotic medications, and a response to the negative effects of the 'total institution'. Critically, it may be observed that bureaucratic regulation of the modernisation of mental health services may be significantly influenced by the multi-million pound pharmaceuticals industry. It is possible that the facets of the

relationship between public health bodies and drugs companies has assisted in the progressive moves towards a community care agenda where the drugs economy is held up by the bureaucratic decisions disseminated within health services.

Rapid closures of county asylums has been evident most notably since Enoch Powell's 'water tower' speech (1961) and further progression in the reduction of hospital occupancy with the introduction of the National Health Service and Community Care Act (1990). For those nursing and allied staff working at this time, this was a period of, operationally; change, instability and redeployment. But additionally, a change in the philosophical underpinnings of mental health care towards one of community integration/rehabilitation, and less of a socially segregated institution-based care. The following extract from Community Specialist Practitioner Chapman's narrative account illustrates this period of political, organisational, ideological and occupational change:

Nursing in the community is the big change for me. When I was here in the eighties there were 2,000 patients in the hospital. The beginning of community care for me was at that point I remember going and being told that there would be a rehab ward opening. These patients that had been in for years and institutionalised; they all had to be rehabbed [psycho-socially rehabilitated], we were told. There were really no more patients left in the hospital that could be rehabbed to go and live in the community. There were still loads of patients that really weren't rehab-able. But when I came back from a career break, they had all gone. The thinking was that we don't put people in institutions anymore if we can help it, we look after them at home and try and keep them at home.

(Community Specialist Practitioner Chapman; CRHT Team)

The decline in hospital occupancy was, by some, heralded as a success, and it was believed that a more therapeutic care plan for recovery could be formulated in the community setting. Economically, community care also functioned as a cost-saving exercise, as many Victorian asylum buildings were becoming increasingly below par in respect of living accommodation for service users. Occupancy fell from 103,300 in 1970 (Department of Health and Social Security, 1970 cited in Scull, 1989, p.312) to 26,928 in 2008 (RCpsych, 2009).

In response to the allocation of large numbers of long-stay inpatients to the community, the expansion of the private mental health sector has continued to become more and more evident, so too, the development of services emerging from the third sector charities to support the daily living of mentally unwell individuals in the community. During the progressive shift of services based predominantly in the community, anxiety was felt over the appropriateness of some of the resettlement of long-stay patients. Staff Nurse Peterley describes this further:

You know, there was quite a lot of ill-feeling amongst staff when they were emptying the old hospital. Some patients were not fit to leave the wards, or so we thought, they needed looking after... some people just need looking after on the wards. I stayed working in the hospital, and you would sometimes see old long-stay patients around the hospital grounds, they would sometimes come in for a dinner if there was a spare one going. They were institutionalised, some in their fifties that had been here since their adolescence. I felt sorry for those... it must have been a frightening time.

(Staff Nurse Peterley; Humber Acute Ward)

It appears that political changes, such as the National Health Service and Community Care Act (1990), have had far reaching impacts. Not only have they influenced and altered traditional care practices, but also transformed ideological and philosophical perspectives on care. The morality dimension endured by staff has also been raised, indeed, a perhaps under acknowledged aspect of political and legislative change, but non-the-less, a poignant and important facet of the emotional aspects that form the normative structures of mental health work.

Two further examples of political expedience that have been highlighted in worker's narrative have been; the NHS anti-smoking legislation, and the 2007 amendment of the Mental Health Act. Both serve as examples of the impact upon the organisation and work routine, but also illustrate how legislative developments are an integral component of a normative order of work for mental health professionals. Those working at the forefront of services are tasked with the administration and enforcement of this legislation, thus it

dictates the direction, standard and scope of social action within the worker-client interface.

Broadly, Weberian perspectives on social action concern themselves with the intercourse of human action within the cause and effect of social situations (Weber, 1922). These perspectives assume that where an undesirable outcome is possible, then steps will be made by the individual in order to attempt to alter this potential negative conclusion. However, for those working within a regulated environment, a structural component is evident in governing the social actions taking place. Here, legislation becomes a structural component that governs the social action between workers and service users. This has implications for this relationship and how each party interprets the effects of interactions as these are already partly determined. Personal discretion in the application of legislation, and more broadly, rules of the organisation, becomes increasingly limited as a consequence of stricter and more encompassing legal and organisational governance. What follows are some examples of the staff perspectives on the development and introduction of stringent legislative reforms, and how these sculpt social actions taking place in the mental health setting.

The smoking ban came into force in England on 1st July 2007. Since this date, it has been an offence to smoke in enclosed public spaces, with enforceable fines to the individual, and to businesses failing to comply being warned. Rooted in a health promotion philosophy that would underpin legislation, acute NHS hospital sites went 'smoke-free' in 2006. Abstentions for NHS mental health Trusts came to an end in July 2008. A commissioned review of the literature by Action on Smoking and Health and conducted by McNeill (2001) reported that over seventy percent of people with psychotic disorders residing in institutions smoke, fifty-two percent of these smoke heavily. Prior to reforms, mental health wards managed this with designated smoking rooms. Hollybrook hospital, like others, enforced a graduated smoking ban which at first prohibited smoking on wards, and then further extended to a total smoking ban in the grounds of the hospital. Nicotine replacement therapies and smoking cessation advice were

plentiful and staff trained in supporting service users to stop smoking. In looking at the implications of the ban and asked whether the ward runs smoothly, Staff Nurse Thomas replied:

The biggest impact recently is the smoking ban. To try and police it and the difficulties arisen from aggressive patients and the infringement of what they see as their own civil liberties, erm antagonises the situation on the ward and puts staff at risk. It has put me at risk I have been hit twice due to implementing the smoking ban. In all my time in nursing I have never been hit before, but it has happen twice in as many weeks due to the smoking ban. That shows how policy changes influence our work so dramatically.

(Staff Nurse Thomas; Humber Acute Ward)

Challenges had been faced in the enforcement of smoking bans early in the NHS 'smoke free' programme. Three quarters of acute trusts were researched and fifteen sites visited. In ninety-four percent of the sites visited, smoking was observed amongst patient/visitor populations (Ratchen, Britton and McNeill, 2009). Concern was also raised about the eligibility of hospitalised mentally disturbed individuals to be included in this programme. Jochelson and Majrowski (2006) researched staff attitudes towards a smoking ban in psychiatric units. Ninety percent of 150 responses from nursing staff were against a smoking ban on psychiatric wards. Respondents commented that; 'patients use smoking as a de-stressor. Many cannot cope without a frequent cigarette.' Another stated 'a ban will lead to total rioting! It will cause mental deterioration and agitation leading to violence and aggression'.

Significant problems have been encountered in the deprivation of smoking for formally detained service users and those subject to therapeutic observation²⁵. Those participants working in the inpatient environment have described some of the challenges faced in enforcing a ban on those unable to leave the hospital grounds. Participants have reported that verbal and physical aggression has been increasing and that their work has become increasingly difficult.

²⁵ Therapeutic observation requires the monitoring of the safety of an in-patient by a member of clinical staff. These checks will occur at time intervals dependent upon the level of risk assessed.

Staff Nurse Hoy commented:

The no smoking policy that came in has caused more paperwork because of the amount of incidents associated with it. It's a massive problem. I didn't come into the job to do paperwork or be an office worker. I came to nurse. Now you spend less time with patients and more time in the office unfortunately.

(Staff Nurse Hoy; Thames Acute Ward)

Staff Nurse Dignan expressed concerns when describing the ward environment:

It is a nice ward, its spacious; the rooms themselves cause problems with plumbing. There is a smoking ban on the wards and this has caused a few problems as some patients find it difficult as at one time we had a smokers lounge, but now that has gone. This can be a cause of upset amongst patients and also we have had problems with patients smoking in their room which is a safety issue, so I am concerned that at some stage there may be a fire on the ward because of this no smoking legislation.

(Staff Nurse Dignan; Humber Acute Ward)

In addition to incidents of physical and non-physical violence, the smoking ban has also been seen to challenge the therapeutic engagement of clients in the ward environment. Staff Nurse Tonry explains that for those service users who can leave the ward unescorted:

Clients are in and out all day really, with staff or on their own. Especially with the no smoking policy in the hospital grounds, many go off the grounds for a smoke. For some this is a big issue because they smoke an awful lot, maybe 20, 40, 60 cigarettes per day. Therefore you don't see them for most of the day. When we had a smoke room on the unit, it was used all the time, but now they are off the grounds and we don't see them much at all. It's difficult for staff to engage with them when they aren't on the ward. You try telling someone that they can't have a fag for two hours because they need to be escorted by staff, and you are busy, it doesn't work. It's a shame that you don't see people for hours on end; they are losing out a lot.

(Staff Nurse Tonry; Trent Intensive Rehabilitation Ward)

As has been seen, implementation of the smoking ban has had wider implications than perhaps first thought. Whilst the overarching health promotion message which this legislation serves remains a salient and key issue, the

administration and enforcement of this has incurred a variety of obstacles for staff. Maintaining a balance of care and control is a tenuous undertaking, however, enforcement of additional rules has the tendency to shift the care-control pendulum off balance, aligning the work of clinical staff more with that of stricter governance and authority. This appears to bring the rationality of policies into question. Dominant health promotion agendas appear to be devoid of little more than superficial input by hospital based practitioners. The difficulties of the implementation of such strategies, as has been illustrated, require the perspectives of those who implement them to the end user. Without this, policy takes a managerial and bureaucratic dominance with little regard for the views of those tasked with administering them.

Such demands placed on those at the forefront of service delivery indicate further the hierarchical differentiation within the bureaucratic structure. Social and political policy has taken a dramatic shift in attitudes towards smoking. Previous decades represented a government heavily profiting from taxation on cigarettes and in a somewhat ironic u-turn have now chosen to ban it. Yet, those governing the action on smoking do not have to endure the difficulties of implementing such a ban directly. Such a distanced relationship between ‘decision makers’ and ‘implementers’ can be interpreted as further evidence of how a suppression of power and autonomy of shop-floor staff reduces hindrances to those higher in the bureaucratic hierarchy.

During fieldwork, a major change in mental health act legislation was taking place. The Mental Health Act (2007) came into effect operationally at the beginning of November 2008. This legislation illustrated a fundamental change in policy sanctions for mental health services nationally. The previous Act had been operational for over twenty-five years, something which many staff have worked within for the majority of their healthcare career. Key changes included the abolition of a ‘treat-ability test’ in favour of ‘appropriate treatment being available’²⁶ and community treatment orders (CTOs). Little has changed in terms

²⁶ See Office of Public Sector Information, Public Acts of Parliament- Mental Health Act 2007 available from http://www.opsi.gov.uk/acts/acts2007/ukpga_20070012_en_1

of some of the operational criteria of the Act, for example, sections of the Mental Health Act. However, it has been widely reported that the new Mental Health Act (2007) represents a 'beefing up' of control measures (Mental Health Alliance, 2007) manifested in the ability to detain individuals with personality disorders, and to recall service users in the community back into hospital much more quickly. Psychiatry now finds itself dealing with significant dilemmas surrounding care provision. On one hand total community care is problematic, not least through momentous failures in supervision (for example, murder of Jonathan Zito). On the other hand, mass institutionalisation of the mentally ill would attract similar criticisms to those in the latter part of the twentieth century. As a consequence, staff are put under increasing pressure to reconcile with current policies and procedures in the context of there being strong external criticisms of both community and hospital care.

Staff Nurse Dignan explains that:

Politicians decide how much money is allocated to mental health and which area of mental health the money goes to. I mean there is a revision of the Mental Health Act currently, so training is being attended by staff, and obviously implemented by parliament. We must be conversant with that new Act which requires additional training for staff. Everything really that is decided centrally and locally impacts upon the staff on the ward and at times it is very difficult to keep up with new policy and change.

(Staff Nurse Dignan; Humber Acute Ward)

Not only do these dramatic legislative changes impact upon the relationship between health professional and service user, but also the overall stability of the work environment. In addition there is potential for such measures to conflict with other policies and good practice guidelines advocating 'good' therapeutic relationships with clients. The mandatory movement towards more authoritarian aspects of their role (for example, denying permission to smoke) can contribute to wider dysfunction amongst staff and a breakdown in the relationship between those administering the rules (shop-floor health workers), and those making them (senior management executives and governmental officials). This is well illustrated in comments made by Staff Nurse Weaver:

When the smoke ban came into force, we had a number of problems on the ward. We had detained patients who wanted to leave the ward for a cigarette, but they were a high risk of absconding. We had detained patients who wanted to leave the ward for a cigarette, but we didn't have enough staff to escort them. It was fast becoming a nightmare. Patients were saying that we were depriving them of their civil liberties. We, as staff, asked the managers to come down and talk to the patients about the ban, as we thought that senior management would be more persuasive. But this took some time to happen.

(Staff Nurse Weaver; Thames Acute Ward)

Staff Nurse Weaver's comments above highlight a practical example of the fraught dialogue between shop-floor staff and managerial practices. It appears here that the interpretation between autonomy and support has become blurred. Whilst it has been observed earlier in this chapter that staff experience a dilution of professional autonomy as a consequence of policy and procedure, it is evident that this is not an opportunity for staff autonomy, but rather a request for support. This has been met by resistance, and provides evidence of the division in staff-manager relationships in the context of difficult-to-implement policy initiatives.

Other institutions have faced similar criticisms to their organisation. In an examination of management in custodial environments Coyle (2008, p.237) states that 'hierarchical structures are only tolerated when the organisation is stable and not under pressure'. To a large extent, Coyle's (2008) statement provides some illumination of what appears to be a somewhat brittle relationship between staff and management. Narrative interviews have highlighted aspects of the disaffection between the two staff 'strata'. However, as Coyle (2008) alludes to, this disaffection must be observed in relation to the background of rapid and radical change taking place. Perhaps, to some extent, the hierarchy is tolerated less by workers due to the political and legislative developments taking place, the unpredictability of daily work, and the blurring of occupational responsibilities, with management becoming the scapegoat, through little fault of their own. On the other hand, as shown throughout this

chapter, such criticism may be deserved in light that policies are being disseminated to staff that are not conducive to the lived environments of workers and service users.

‘That’s how the tide has turned’; A New Organisational Culture

There is always an underlying current of where will you be this time next year – will the ward be shut or not? I’m more of a day to day man because you don’t know of what is around the corner, there is no guarantee of stability in this job anymore. I have no big plans for a change of direction anyway.

(Staff Nurse Hoy; Thames Acute Ward)

The statement above captures the essence of the situation which many contemporary mental health workers find themselves within. The advent of Foundation Trusts, budgeting and cost saving within the NHS are all taking their toll upon the staff and ultimately their outlook on their work. Staff at Hollybrook hospital report recent years of instability, not just in relation to political, legislative and policy initiatives, but also changes to their physical working environment and the development of their mental health trust as a NHS Foundation Trust. Affecting both community based staff and hospital practitioners, organisational development at Hollybrook hospital has not discriminated in who it impacts upon (albeit in different ways).

Organisational culture, as a product of these multiple changes, has altered itself. Whilst many have understood the complexities of identifying organisational cultures (Smircich, 1983; Crawley, 2004), with little consensus on what constitutes one, broadly, an organisational culture is to be socially defined and observed by those who experience its attributes (Schein, 1990). Here, through the participant’s comments, a shift in the organisational culture can be witnessed. Drawing from personal accounts, changes to the physical working environment, development of specialised ‘for profit’ services, and new working practices (for example, the Acute Care Model) can be seen to represent the

formulation of a new organisational culture. In addition, occupational cultures amongst staff exist. These should not be confused with the former, as these represent collective social and emotional responses to the imperatives of work. Therefore, particular characteristics, symbolisms, stories, rituals and ceremonies within the occupational culture(s) of the workplace become illuminated as they respond to changes, developments and shifts in the organisational culture.

The move into purpose built premises at Hollybrook hospital in 2005 from Victorian asylum buildings has been an established theme throughout narrative accounts of mental health work at Hollybrook. According to Goffman, (2007, p.107), those working on face to face basis with patients are considerable 'tradition carriers'. Since moving, several alterations to inpatient services have taken place, including the closure of an acute admission ward and functional older peoples' ward. Technical Instructor Pervis's personal description highlights some of the challenges faced:

Everything changed overnight. Well not everything, but over the space of a year, there were redeployments, new services, services shut down, cost cutting, new policies, and computerisation. All these things changed the way of working totally. There were no traditional ways of working anymore. Autonomy was changing through new policies and rules. Staff groups had been split; there was a lot of sickness and absence. Nobody knew where they were at, and the types of patients coming in were different. There had been a reduction on beds, so on a ward of twenty, they would all be acutely unwell, instead of a balance of unwell and those on way to recovery. You could see that staff were getting burnt out, seriously burnt out.

(Technical Instructor Pervis; Avon Occupational Therapy Service)

Furthermore, the advancement of cost-effective services has had a bearing upon workers' outlook on their role. Occupational Therapist Gannon, provides a perspective on her personal and professional view of the recent changes experienced:

Clinically I still love the job and I enjoy the management side of things but there has been so much change and having to manage your staff through that change and responding to that change has been quite

stressful really and has been the thing that has probably taken the joy out of the job for me really. I know that is what it will be like forever, so there we go. The changes have been, first, moving from one hospital to another and that was an extremely exhilarating but stressful time because I put in a lot of hours on that move because there wasn't enough support in terms of getting things from a to b. And I would come in at the weekends, brought my husband with me and we put cupboards together that had arrived because yes there were cupboards there but they had no shelves and things were moving the next day.

I put in a tremendous amount of hours and also we had fantastic new facilities but actually the impact of working within new facilities and developing new risk assessments and new policies around how you work and new working practices, that after being secure and safe in the same environment for so many years and having a traditional way of working meant that it was really stressful and I put in so many hours in order to get that established and support the team to take that on board and re-establish where we were and how we worked. It was just incredibly difficult. I was working so many hours and I absolutely got to the point where, I didn't see it my self, but I was burnt out, and ended up going on holiday for a week and not being able to go back to work (*laughter*). I was exhausted and I think that you can keep going and going, and I have got a massive capacity for work me, I do huge amounts of work and will fill whatever gap needs to be filled, and I had just filled too many gaps. It had been going on for too long, so I ended up being really, really stressed. I took two weeks off only, which I was really proud of and then I was back.

It has been a really rocky ride in this post and it has been quite stressful at times. I don't see that ever ending, and I think will continue to change dramatically and always times when I will feel stressed but that's the NHS now. The world I experienced years ago doesn't exist now.

(Occupational Therapist Gannon; Avon Occupational Therapy Service)

Here, Occupational Therapist Gannon is explicit that ways of working now are starkly different from those prior to the move to new premises. It appears that since the move to new accommodation, this has been a time chosen for strategic development and the nurturing of a new organisational culture. Moving away from Victorian asylum accommodation has been of considerable importance on central and local modernisation agendas. The advancement of anti-stigmatisation programmes has required not only attempts to change public attitudes, but also a visual stimulus to this by the removal of socially symbolic asylums of confinement.

Community based services such as the Crisis Resolution Home Treatment (CRHT) team have not been immune to recent developments in their services. Efficiency and clinical effectiveness have been brought to the forefront of the organisational culture. A degree of measurement and quantifying has become integral within many dimensions of mental health work. In a culture of cost-efficiency, monitoring and audit has become much more customary in day to day occupational routine. 'Traditional' services such as admission wards and 'new' services such as CRHT both undergo similar efficiency scrutiny. Clinicians within the CRHT have also become engaged in a bed management role, in order to screen and regulate hospital admission, offering home treatment where appropriate and possible.

As a consequence of bureaucratic change, and the national commissioning of CRHT teams, a tenuous relationship between ward and CRHT staff has emerged. Prior to CRHT Community Specialist Practitioners screening hospital admissions, ward staff were influential in assisting medical staff in the admission process. Now, CRHT staff assess with medical staff and sanction admission if necessary, taking control of bed management responsibilities. At times, a tension is evident, as ward staff become less involved in who is admitted and who is not, an aspect of the role which had traditionally been maintained. Now that this role falls with non-ward staff, there is a perceived expectation to gate-keep effectively, and to only admit what are viewed as 'appropriate' and 'manageable' individuals (see Gallop, Lancee and Garfinkel, 1989; Phillips and Johnson, 2003; Richmond and Foster, 2003 for explanation of nurses attitudes towards patients presenting with co-morbid addictions and personality disorder.).

As has been discussed earlier in this chapter, inpatient ward staff express that their autonomy is becoming eroded as new bureaucratic decisions are made. The role of the CRHT practitioner as bed manager has perhaps gone some way in exacerbating this further. Community Specialist Practitioner Hunt explains:

I think initially when we first started to develop the bed management role; we had the final say of who is admitted and who is not. I could see where they were coming from. In my role as a Community Mental Health Nurse, you know you train the same as them! They got a bit 'uppity' and felt we had deskilled them, but it wasn't about that really, it was about managing the beds. Because of the risk management that we do all the time, I think other staff in other teams and on wards, and Consultants even, have never had to deal with a *nurse* telling them yes or no before.

(Community Specialist Practitioner Hunt; CRHT Team)

The advancement of the role of the CRHT practitioner and their involvement in the occupancy of hospital admission wards (for example, admission and discharge) is specifically correlated with strategies for cost effectiveness and swift and effective patient recovery. This role not only gate-keeps the clientele of the hospital, but also is influential in maintaining the make-up of the 'total institution'. McEwen (1980, p.149) states that Goffman's 'total institution' model is an 'ideal type' of organisation in the tradition of Weber's bureaucracy. In this sense, the operations of the 'total institution' are heavily dependent upon particular bureaucratic goals. In the case of the developing autonomy and power of the CRHT practitioner, the in-patient clinician becomes subordinated in respect that their daily social and work experiences become dependant upon who the CRHT practitioner deems acceptable for admission to hospital. In-patient staff become less autonomous in this respect, their professional expertise becoming diminished, and succumbing to the influences of the 'total institution' to a greater extent. Staff Nurse Rumsey explains that:

You know, it was much better when the ward staff or the bleep-holder went and assessed people in A&E. The doctor would ring the wards and ask advice or if we knew the person. That meant a lot. Now it's out of our hands, the Crisis team will ring us to arrange a bed for someone they have assessed, and that's the first thing we know. I know its one less job for us, but I think on the whole we liked the involvement. It was useful as often they would be revolving door patients in A&E and you knew that hospital would be no good for them, so you would advise the doctor of that. Illicit drug users being admitted can be challenging for everyone.

(Staff Nurse Rumsey; Humber Acute Ward)

Richmond and Foster (2003) have pointed to the situation which can arise as a consequence of illicit drug users in mental health services. In itself, illicit drug (ab)use is excluded under the Mental Health Act (2007), however, service users are frequently admitted both formally and informally where drug or alcohol use is complemented by other symptoms of mental abnormality. Research has revealed that at the interface between mental health professionals and the drug dependent service user, staff reflected moralistic judgments and reduced treatment optimism (Richmond and Foster, 2003). Staff Nurse Rumsey describes her standpoint on this further:

Some of my worst shifts have been those where we have an unsettled ward. It only takes one or two to disrupt the milieu. I know drugs and alcohol are becoming more and more available in society, and I suppose that means we will see a lot more in hospital. Come to think of it, we have always had patients with drug problems, so its nothing new really. One of the most difficult things though is sorting out medication such as methadone and benzo's [benzodiazepines]. You have to sort out prescriptions with the G.P. easy said and done during 9-5, come the night it's a bit more difficult. We have policies on the prescription of things like this out of hours, but sometimes the patient can become demanding and in your face. The other problem from time to time is illicit drug use on the ward. We have had the police in before now, but more often than not visitors will bring drugs in for patients. This is really difficult to detect, and at the end of the day, it detrimental to the other clients on the ward and the running of the ward. It can also make us look like fools for not stopping it, but its not that easy.

(Staff Nurse Rumsey; Humber Acute Ward)

Staff Nurse Rumsey's accounts are supported in the study of the permeability of the 'total institution' conducted by Quirk, Lelliott and Seale (2006). They explain that ward staff become important agents in the control of borders of the 'total institution'. Staff are tasked with managing the ingress of outside factors (for example visitors and drug supply) into the ward environment. This then becomes an additional task for nursing and allied hospital staff. This is also a task which has the potential to cause altercation and confrontation between client and staff. As has been illuminated by Staff Nurse Rumsey, these potentially volatile and problematic situations can be closely associated with, as

Richmond and Foster (2003) have found, limited optimism in successful treatment of the client.

For some staff, such as Staff Nurse Rumsey, these social encounters may be avoided with careful assessment prior to admission. A task once undertaken by ward staff is now bestowed with the practitioners of the CRHT. An element of powerlessness is then felt amongst inpatient clinicians as they no longer have a valuable stake in the decision making process of who is admitted to wards and who is not. Control of the parameters of the 'total institution' becomes entrusted with senior practitioners (Band 6 and 7) rather than ward staff nurses (Band 5 and 6). A shift towards specialist knowledge for assessments opposed to experiential knowledge of service users has become evident, affecting, to a large extent, the autonomy and involvement of ward based staff in the admission procedure.

Admission wards at Hollybrook hospital are, in recent years, predominantly characterised by the acute mentally unwell. Previous to this, admission wards consisted of a blend of both chronic and acutely unwell service users. The closure of an admission ward and the consolidation of admissions onto two wards have seen a funnelling of the acutely unwell. Whilst research evidence and policy directive point towards improved recovery of chronic service users in the rehabilitation and community setting, instead of the admission ward environment, considerable pressures are felt by staff faced with work on wards where consistent high occupancy meets with a high prevalence of acute disorders.

The closure of an acute admission ward at Hollybrook hospital can be attributed to three main issues. The first a financial saving imposed by the Primary Care Trust, secondly the development of the Acute Care Model (ACM) and thirdly the efficiency of the CRHT team. Potential admissions into hospital are assessed by nurse practitioners of the CRHT. They work alongside medical staff in assessing what types of treatments are appropriate for the symptoms presented. These may be a range of referrals such as hospitalisation, referral to primary

care services (G.P.s, counselling, psychology, alcohol services, etc..) or the implementation of a home treatment plan. The assessment services are operational on a twenty-four hour basis, and will assist liaison practitioners or junior doctors in deciding the best course of referral or treatment. During the assessment of potential service users, CRHT practitioners have considerable influence and autonomy (to the extent that junior doctors can at times be overruled by CRHT practitioners), which was once predominantly retained by medical staff. The CRHT practitioner therefore becomes a representative and key gatekeeper of inpatient services, ultimately affecting the character of the membership of the 'total institution'.

The CRHT practitioner's role has become broad. They are influential both in assessment and in implementing the support of early discharges from hospital as well as home treating many individuals. Their role becomes progressive and their remit expansive as new frameworks of care and treatment develop, not least the Acute Care Model (ACM). Divisions between ward based staff and CRHT practitioners become more prolific as the CRHT practitioner role develops and the role of ward-based staff remains static. Cultural differences between the occupational groups form as a consequence of difference based on one another's roles indicative of attitudes towards competence and effectiveness (see Chapter 6). Bureaucratic developments in the community and inpatient setting, and the nature of hospital work (more broadly the operations and character of the 'total institution') stages distinctive differences between the two groups based on perceptions of the self and the other (Goffman, 2007, p.104). Narratives allude to the vigorous and ever changing nature of Crisis work in addition to their authority over bed occupancy. Ward staff, conversely, manage symptoms and behaviours through treatment and prolonged interventions although hold less autonomy in the admission and discharge of service users.

Whilst the role of the CRHT and its workers may be seen as dynamic, developing and autonomous, there is also substantial anxiety amongst members of the CRHT team because of this. They are perhaps one of the occupational

groups who are the most expedient of political and local planning and service re-design:

Another government and the team could disappear. We are very new, but how long will we last? Other areas of the country they have got rid of them [CRHT teams]. Burlington was one of the first; they had a Crisis team very early on, before everyone had to have them. They actually closed that and changed it to more of liaison type work.

(Community Specialist Practitioner Chapman; CRHT Team)

Furthermore, Community Specialist Practitioner Watts perceives a future where the CRHT is disbanded and describes that:

It's becoming more like a business. The Crisis Team may be disbanded, maybe onto the wards to improve and speed up early discharges. Maybe the other half working will be with Community Mental Health Teams as specialist workers. It would have a huge impact on people's welfare and reduce hospital admissions, and improve on all the targets this place aims to achieve I guess. There is a good chance it will sink I reckon, we are at the hands of the decision makers.

(Community Specialist Practitioner Watts; CRHT Team)

In-patient staff appear also to share some of the anxiety about the future of their occupational position. Organisational change and the anxiety which staff members express are perhaps exacerbated at the time of data collection by the national and global financial crisis. In response to economic deficits caused and prolonged by economic recession, political (from all major parties) 'sound-bites' emerge discussing the inevitable cuts in spending on public services. Gordon Brown, in a statement to G20 finance ministers stated that:

Our tough approach will be based on an approach of frontline first: to shift resources from areas where we can achieve greater efficiency, reducing costs where we can, selling assets we no longer need, and giving priority to investments that can secure the jobs of the future and deliver improved frontline services for the general public.

(Brown cited in Wintour, 2009)

Furthermore, David Cameron elected Prime Minister in May 2010, has pledged radical NHS reforms 'from day one' and the Tory leader attacked Labour's 'spendaholic culture' and repeatedly said he wanted to deliver 'more for less' (Cameron, cited in Nursing Times, 8 March 2010). Anticipating the future is proving somewhat difficult for many of the participants interviewed in this study. Job security has progressively become a dominant theme amongst many working in the contemporary health labour market. To date, mandatory redundancies have been avoided at Hollybrook hospital, however, redundancies in the NHS have become a very real occurrence in recent years. Most prolific has been the re-organisation of Strategic Health Authorities (SHAs), which, following information obtained by the BBC via a 'freedom of information request', shed 764 jobs during 2006/07 through redundancy and early retirement options. Likewise, Hollybrook hospital qualifying employees received letters asking for an expression of interest for those approaching early retirement ages. Additionally, redeployment and rotation of staff following service redesign have further raised concerns over occupational stability. Staff Nurse Tonry's explanation is typical of many views held in this study:

When I first started, we were in a big old asylum building; staff had been there for years. Now you work for the Trust, and not on a ward. It gives you a feeling that you could be working anywhere, there is no certainty anymore. There is some certainty that you will have a job, I hope, but uncertainty where you may be working and could be anywhere in the Trust. Economic stuff is changing all the time. People aren't as certain about their job as maybe they used to be; even over my 8 year career I have seen this change. People don't know where they will permanently be anymore.

(Staff Nurse Tonry; Trent Intensive Rehabilitation Ward)

Much can be drawn from the narratives provided by participants in this chapter that illustrates the burdening effects of bureaucratic regulation on forward face staff. The Weberian theorisations of bureaucracy appear highly germane to the structured environment clinical staff operate within. Weber (1922) puts forward that there are a number of assets that make up the character of an 'ideal type' bureaucracy. According to Weber (1922), modern bureaucracy includes; impersonality, concentration of the means of administration, a levelling effect

on social and economic differences and the implementation of a system of authority that is resistant to outside influences. This Weberian outlook on modern bureaucracies was in response to growing levels of production and growing political sophistication.

For Weber, the ideal bureaucracy is focused around a concept of rationality. This is meant to represent a system by which sanctions and operations are delivered via the systems of the organisation and not by individual with undisputed biases. Systems which incorporate degrees of rationality into their approaches are seen by Weber (1922) to promote the core values of the 'ideal type' bureaucracy. Yet as has been seen, rationality within the bureaucratic structures at Hollybrook hospital may be disputed due to the lack of stakeholdership of the shop-floor staff groups.

Weber's (1922) thesis on the ideal bureaucracy has been much criticised, not least because it is seen as unrealistically utopian. Weber's (1922) concepts focus heavily upon the schemas of productivity and efficiency but focus little on the social constructions within these bureaucratic organisations that shape their existence. For this reason, writers (for example, Lipsky, 2010) have argued that it is necessary to observe the social constructs that contribute to a bureaucratic organisation rather than assuming, as Weber (1922) does, that the 'ideal type' bureaucracy is immune and defensible from issues such as internal power struggles and vested interests of officials.

Many of the narratives presented in this part of the study illustrate a situation which can be best illustrated by the work of Crozier (1964). He challenged Weber's (1922) belief that bureaucratic organisations are motivated by efficiency and rationality and explored some of the reasons why organisations became dysfunctional. Crozier (1964) explains that where, for example, workers are placed in a situation where many outcomes for situations have been decided in advance (for example strict policy and procedure), and the only way for people to gain control and re-assert their professional autonomy is to exploit any remaining 'zones of uncertainty'. Crozier (1964) suggests that organisational and

occupational relations become little more than strategic games that attempt to suppress or exploit such zones, either for their own personal ends, or to prevent others from gaining an advantage. Crozier (1964) posits that a result of this is that the organisation becomes engaged in a series of internal power struggles, a situation certainly evident from the views of participants in this study. These struggles have been made evident in particular in the administration of policies by mental health workers. The smoking ban represents a disjuncture in this relationship and a breakdown of interaction between levels of hierarchy. These 'vicious circles' further exacerbate divides and formulate a working culture where conflict and consensus are rarely met easily (Crozier, 1964).

Pre-determined decisions of the organisation, such as policy and procedure, are designed to address extra-ordinary events and organisational imperatives. However, as the bureaucratic system employs impersonal rules that govern the predetermined behaviours of employees, hierarchical relationships become less important and the senior levels lose the respect and power to govern. Informal practices emerge as a product of such situations (see Chapters 6 and 7) and work, to some extent, becomes governed by dominant informal norms. Such approaches are highly criticised as impeding organisational development and occupational subcultures that define informal practices demonised as militant counter-cultures.

For Crozier (1964) the process by which the impersonal rules are manufactured is important also. So as to maintain the impersonal and generic nature of decision making, decisions and directives must be made by people who cannot be influenced by those who are affected. Narratives in this study support that the effect of this is that problems are only resolved by people who have no direct knowledge of them and the rule makers become less and less visible and more and more anonymous.

The restriction of bargaining and negotiation are important aspects of work which Crozier (1964) attributes to bureaucratic dysfunction. Where it is seen as impossible to negotiate with pre-determined and inflexible rules, Crozier (1964)

suggests that this acts as a catalyst to the development of isolated strata (divisions in staff groups). Staff strata will develop particular occupational norms which result in a process of enculturation or peer group pressure to conform to the norms of the strata regardless of individual beliefs or the wider goals of the organisation.

Where groups form with value solidarity, Crozier (1964) explains that these groups gain control of the 'zones of uncertainty'. This can become highly visible (for example, industrial action) or discreet (for example, informal work practices) as these groups then become able to wield disproportionate power in an otherwise regulated organisation. Power investiture in these sub-strata leads to the creation of parallel power structures between senior managers and subordinates, which in turn can result in a focus of attention towards particular staff groups or threats to organisational efficiency or function.

Part Two: Risk Management

The identification and responses to risk have long been an area of discussion, debate and criticism. The work of Foucault, (1991), Beck (1992) and later Giddens (1998;1999) on the formulation of levels of social risks, have pointed towards the understanding of the origins of risk and the ways in which this issue is socially defined and responded to. The risk society, first coined by Ulrick Beck (1992) captures an understanding of how modern societies have organised themselves and their institutions in response to perceived risks. Furthermore, Foucauldian analyses have attempted to understand how particular social institutions are key evidential components that shape understandings of risk. For Beck (1992), risk has emerged as a dominant narrative in society as a consequence of human activities (for example, capitalism and failures in scientific advancement for example, Chernobyl) and anxiety amongst societal members is compounded by the perception that so-called social insurances are incapable of alleviating the problem (for example, health and welfare systems). The management of those who deviate from societal and cultural norms,

therefore, in the view of the state, require some intervention in order to provide some insurance against risks that they *may* pose, however such risks are largely unknowable.

In this section, narratives are provided by both in-patient and community staff. Staff Nurses Carrington and Rumsey allude to the management of risk within the in-patient context, whilst Occupational Therapist Wetherby and Community Specialist Practitioners Wakefield, Hunt and Cahill explain the challenges that they face. What is apparent, is that risk and risk management maintains a position of a *grand narrative* in terms of their assessment, delivery of care, individual management of risk responsibilities and employee's personal outlook on their role.

State endorsed agencies become the mechanism by which risk is managed, and as a consequence, measures of formal social control are often implemented in order to 'seek strategies that minimise the aggregate levels of risk' (Rose, 1998, p.177). Moreover, operatives of such agencies tasked with maintaining social control and the minimisation of risk to societal members become integral and enactive participants in the delivery of risk agendas. Rose (2000, p.332) posits this eloquently when he states; '[t]he very gaze of the control professional and the nature of their encounter with their client, patient or suspect, is liable to be formatted by the demands and objectives of risk management'.

The development and delivery of risk management initiatives is grounded in wider psychiatric discourses of control. Those diagnosed with symptoms of mental illness are instantly aligned into a group separated from orthodox expectations of social conduct. Whilst risk management may address practical problems of protecting society and safeguarding individuals, socially the assimilation into psychiatric diagnoses has capabilities to heavily stigmatise individuals. Risk management, therefore, serves as an additional coercive mechanism introduced to facilitate the management of those deemed as warranting levels of social control.

The management of risk in the National Health Service is of pivotal importance to the daily discharge of an employee's duties. Workers must manage their work within a framework which corresponds with organisational governance and procedure. Strict policies have been developed for the management of risk, not least since the dissolving of the Crown Immunity on hospital premises in the late nineteen-eighties. Risk management strategies have developed as key components in strategic and practical delivery of services, occupying a senior position in the responsibilities of health providers.

Risk management, a main constituent of clinical governance, has gained greater credence as a response to growing levels of accountability held by the organisation and expected by the public. New and existing services are designed in light of developed risk management strategies in order to fulfil public expectations of high quality care, yet at times, faults do emerge and litigation often pursues such events. In response to a growth in the litigation and claims market, the NHS Litigation Authority (NHSLA) is responsible for liaising with Trust officials in order to settle substantive claims. During 2008/09, the NHSLA received 6,088 clinical, and 3,743 non-clinical negligence claims, with 17,899 ongoing claims being investigated (NHSLA, 2009). Furthermore, over £800 million has been spent by the NHS in the settlement of claims during that year (Bowcott, 2009).

Risk management strategies differ considerably between service areas, not least between general medicine and psychiatry. Whilst general guidance and procedure are delivered from central agencies, local Trusts are tasked with the development of risk management strategies particular to their specialities. Practical approaches to risk management in the mental health setting are typically standardised risk assessments such as Clinical Assessment of Risk to Self and Others (CARSO), Threshold Assessment Grid (TAG) and clinical observation policies. The challenge for practitioners in such an environment in the management of risk is that they are often met with complex psycho-social issues bound in high levels of chaotic, unpredictable and multifarious presentations. Workers responsible in such an assessment process are required

to not only engage with risk assessment protocols, but utilise honed clinical judgements. Both these methods are not ‘fool-proof’, and therefore, it is not unusual for risk assessment to fail, sometimes to catastrophic outcomes (For example, suicide, and harm to others).

Managing this responsibility can be difficult, as often practitioners are required to ‘sign off’ on a risk assessment, thus taking personal responsibility.

The really important thing for me is that you need the team to share the risk and agree on a course of action. If you haven’t got that then that is when you get stressed because you are isolated. The team decision thing is really important.

(Occupational Therapist Gannon; Avon Occupational Therapy Service)

Occupational Therapist Gannon illustrates the importance of sharing such a personal and professional burden. Predicting the behaviours of mental health service users is enveloped with uncertainty, and Occupational Therapist Gannon highlights a method of diluting that personal responsibility amongst others in order to maintain robust professional working.

The introduction of rigorous and exacting procedures for the management of risk may well be representative of a growing global litigious culture. Furthermore, ‘public trust is placed in expert knowledge developed through training and expresses through due process’ (MacDonald, 2010, p.1237). However, for some workers at Hollybrook hospital, such procedures have proved an obstacle to their engagement and work. Occupational Therapist Gannon explains further that:

To me, the environment here and managing risk, impacts upon myself significantly and the people who I line manage, because I am constantly reminded to follow procedure. I would say that it is at the forefront of my work as much as deciding therapeutically what to do with someone. You can’t have one without another. That kind of joy and spontaneity of let’s do this or let’s do that I feel that I have lost some of that, without a doubt.

(Occupational Therapist Gannon; Avon Occupational Therapy Service)

Further, Staff Nurse Carrington explains the ways in which risk is assessed, and how this has changed over the course of his employment:

I have been in locked environments for a long time er not through choice but through managerial succession I suppose; it's just the way it came about. I loved Arun ward. When I first got there it was an open door, if you don't like it, the patients could go. You couldn't do that down in London, God you'd be frightened to death if you did that down in London 'cos of the risks. Now you can't do it here. Now they've got scared to let people go out the door and that's where it's falling down. We need to let people take some responsibility for their actions- to some extent anyway; we can't just keep them shut away forever.

(Staff Nurse Carrington; Trent Intensive Rehabilitation ward)

Both accounts by O.T Gannon and Staff Nurse Carrington reflect opinions on how the management of risk appears to have become more cautious and shifted towards increased actuarial practices in the calculation of risk. Calculating the risks that service users present is in no way an exacting science, yet, as some commentators support, it has become fundamental and that 'concerns over risk have become the over-riding driver of contemporary mental health and penal policy' (Seddon, 2008, p.301).

In the broader societal sense, 'identification and management of risks have become structuring principals of contemporary life' (Robinson, 1999, p.422). It is overtly evident that the centrality of risk calculation has flowed speedily into the capillaries of front-facing mental health professionals. Presenting behaviours are assessed, but in a contrasting dimension, probable risk is constructed in a particular way that meets with the political, organisational and profession's needs. In identifying and defining the risks or behaviours in standardised ways, 'these terms can provide the organisation's authority to determine the individual's future' (Crowe and Carlyle, 2002, p.22). In determining an individual's immediate (and at times, long term) future through risk calculation, the organisation becomes somewhat legitimated in its decisions. The very process of managing risk in such an environment through 'expert systems' is

likely also to be bound by much broader, and changing, strategies of public protection, welfare and accountability, for example welfare reform, actuarial criminal justice practices and a growth in coercive psychiatric discourses.

The ‘Crystal Ball’ of Risk Assessment

The process of risk management occurs differently dependant upon the work environment. For those working within the hospital setting, particular risks have been identified already as a reason to admit the client to hospital. Once entering the ward environment, risk assessments will be undertaken on a regular basis (for example, therapeutic observation, requests for leave of absence, discharge from hospital). For those engaged in the assessment of risk prior to engagement with services, risk calculation is much different (see *appendix xi* for an example of a risk assessment pro forma).

Legislative changes in Mental Health Law represent greater potential for the intervention of control systems (for example, community treatment orders, removal of the so-called ‘treatability testing’). Such developments indicate the risk management strategies that aggregate modern psychiatric discourse. Strong comparisons can be made here to Feeley and Simon (1992) thesis of a ‘new penology’ where the governing agendas focus heavily upon social actuarialism, control and broad management of ‘at risk’ (or deviant) groups. A key strand of this new-penology paradigm highlights a movement of concern away from the social actor as an individual, to a more generalised approach to risk management of social deviance more broadly. Risk profiling through ‘actuarial scales’ (Robinson, 1999, p.429) positions the mental health practitioner as one of the primary assessor of risk, but also more broadly, as a key agent at the forefront of this shift in discourse.

The practitioners working within the CRHT team regularly triage and assess members of the public who present with mental distress. They may be known to mental health services, or it may be a first presentation or contact. The CRHT

practitioner will, with liaison from medical staff, assess those who present (usually in the accident and emergency department). They may be referred to primary care services, secondary services, recommended for home treatment or admitted to hospital. Undertaking such an assessment places a great deal of responsibility with the nurse practitioner, a role which was once only completed by medical staff. Community Specialist Practitioner Wakefield and Community Specialist Practitioner Hunt explain some of the complexities of the role:

The Crisis team, so they say, is like a ward in the community. We manage clients that would have perhaps, years ago, stayed in hospital for extended periods of time. It is about facilitating early discharges and assessing those who need hospitalisation. We decide on the most appropriate pathway according to the risks that are presented. We can provide intensive home treatments to avoid the person being taken out of their home to go into hospital. Of course when the risks are high, then hospital may be the only answer.

(Community Specialist Practitioner Wakefield; CRHT Team)

Furthermore:

In the Crisis Team your risk management runs at a fast pace and you develop. Sometimes you can have too high a risk threshold that you have to take a step back and look at the situation. You don't have a crystal ball and sometimes I imagine things go wrong. However, we do the very best that we can. We look at each and every patient very closely. We advise doctors much more now than we used to.

(Community Specialist Practitioner Hunt; CRHT Team)

It appears from C.S.P Hunt's account that management of risk for a CRHT worker is not just about assessing the presenting behaviours of a service user. It also highlights how a nurse's role has diversified in terms of responsibilities, much further than that of staff members in other clinical areas. Risk assessment and calculation in a CRHT team also represents a shift in power and autonomy from the medical profession to the nursing profession, much in contrast to traditional hierarchical structures of responsibility in psychiatry. CRHT staff, in their role as bed co-ordinator outside of office hours, also deal with exerting pressures of bureaucracy.

Nursing staff within the CRHT therefore are responsible for making predictions on the behaviours of those who they assess. They must engage in an assessment of the potential risk of suicide, self harm, self neglect and harm to others. In terms of financial reward for such responsibilities, those working in the CRHT receive a significantly lower salary in comparison to medical staff who had previously undertaken this role (see *appendix xii* for an overview of pay scales).

Such a task may attract feelings of potential vulnerability. Decisions on how best to sign-post the individual will be based upon the worker's calculation of presenting behaviours and feelings. The interpretation and decision made by the CRHT worker will be a blend of presenting symptoms and their own clinical experience. The worker's tolerance, or risk threshold will ultimately have an impact in the decision-making process, however, this can be a burdening situation, with much of the responsibility falling upon the CRHT worker who signs off on the assessment. Community Specialist Practitioner Cahill identifies some of the approaches used to address this:

I think its mixture of working autonomously and working independently and making independent decisions mixed in with a team approach. You could assess a patient one day and another member of staff will go and see them the day afterwards and they present totally differently. You need that team approach- a 'fresh set of eyes' is more than useful. But you also need to be able to have your own assessment of the situation and your own ideas of what might be best for that service user and bring it back and discuss with the team.

(Community Specialist Practitioner Cahill; CRHT Team)

Sharing a burden of responsibility in this way appears to prove effective according to Community Specialist Practitioner Cahill. Importantly, attention towards 'what might be best for the service user' is maintained. Whilst many aspects of the CRHT practitioner's role simulates key actuarial systems (such as quantitatively and qualitatively measuring risk possibilities), attention to the *individual* is still preserved. This evidence resonates with Seddon's (2008) advice to be cautious of the *pure* application of a 'new penology' perspective to

psychiatry. He explains that 'risk technologies are dynamic' (Seddon, 2008, p.312) and that they need to be 'understood as a complex, multifaceted and mobile formation' (p.301). Discussing in the context of the DSPD programme, Seddon (2008, p.312) explains that risk management and calculations 'take on hybrid forms that align themselves with specific political programmes'.

Evidence presented from workers' narratives highlight how despite the quantitative element to risk assessment and management, attention to the 'best interests' of the individual are preserved. However, a pre-occupation with actuarial practices in mental health work is evident. This supports Seddon's (2008) notion that risk management is not monolithic and maintains some fluidity within the psychiatric arena. It has become obvious that risk assessing practitioners are bound by a 'duty of care' that is prescribed professionally and bureaucratically, but also by the benevolent and individualised approach of the caring professions. Yet the pressures to maintain a risk averse system of work are maintained through ongoing training and developing assessment tools, and this likely to take its toll on employees. It appears that the attention toward managing 'at risk groups' through standardised assessments is continually re-asserted in the workplace and becoming increasingly institutionalised.

Working within the procedural context of risk governance, workers abide by set rules and policies as deviation from these are likely to attract unwanted managerial attention. The prospect of personal accountability for occupational (mis)conduct resonates amongst staff. Staff Nurse Carrington provides this insightful account:

The only element of my job that has affected my outlook on my role is the paranoid culture. You are more careful what you are doing now, you might check your medication 2 or 3 times rather than been confident, because you are worried about what would happen if you made a mistake. The blame culture is like a big stick. The big stick is always being waved above your head- and they will use it.

(Staff Nurse Carrington; Trent Intensive Rehabilitation Ward)

Staff Nurse Carrington's narrative above provides further evidence of the incongruous relationship between workers and managers. The possibility of disciplinary action for staff highlights a potential opportunity for humiliation and discrediting of occupational professionalism. Such potential emotional threats upon a worker's 'sense of self' (Goffman, 2007) serve to maintain conformity amongst the staff group. Yet, compliance to organisational structures, therefore, holds implications for the relations between staff and managers (not least where one party finds the other's actions illegitimate) further fuelling a potential antagonistic relationship.

In some cases risk management structures are viewed as a necessity of modern practice. Occupational Therapist Wetherby shows her frustration with such rigid protocols, yet also acknowledges their utility:

Things have progressed a lot in terms of risk management. Risk management is really good in some ways because we are actually looking at the person's needs and things like that very closely. On the other hand it has made a lot of new restrictions and it has meant that we can't just whiz off to Monaghan beach or Downsgate for an ice cream. It's a two-edged sword really.

(Occupational Therapist Wetherby; Avon Occupational Therapy Service)

Occupational Therapist Wetherby's account sheds light on the state of flux that practitioners find themselves within. On one hand they are governed by the political expedience of actuarial practices, on the other, the wishes of staff to engage with service users in a therapeutic way. This contrast of *needs* (governance and responsibilities) and *wants* (therapeutic dimension) serves to represent the frustration that clinicians can experience. Unveiling the occupational dilemmas of this situation draws greater focus to the disjuncture of policy objectives (social actuarialism) and embedded occupational ideas of what is best for the patient. Whilst organisations will argue that policy is delivered in the best interests of the client, this may not be viewed by the workforce as the case. Therefore, policy objectives engendering the demands of the risk society

may change, however the consensus and support for these amongst occupational cultures and groups may be more difficult to achieve.

Think of it on two levels. There is how they want you to be, and there is what is best for the client. It's a battle. I know when I used to work in the community in my old job, things were hard in terms of filling out risk assessments- it's not much different now I suppose. Don't get me wrong, I think risk assessments and the aspects of the Mental Health Act are crucial in our work, but I sometimes think the outcomes aren't necessarily the best possible outcome for the client. They are always edging on the side of caution, when I think; actually, sometimes people need to take responsibility for their own actions and be given a little more freedom.

(Staff Nurse Rumsey; Humber Acute Ward)

Risk management is a complex task for any clinician to undertake. It is something that all employees share some level of responsibility for and is embedded in the developing organisational culture of the NHS. Rose (1998) explains the position which nursing and allied staff find themselves situated within:

[Risk management operates] through transforming professional subjectivity. It is the individual professional who has to make the assessment and management of risk their central professional obligation. They have to assess the individual client in terms of the "riskiness" that they represent, to allocate each to a risk level, to put in place the appropriate administrative arrangements for the management of the individual in the light of the requirement to minimize risk, and to take responsibility — indeed blame — if an 'untoward incident' occurs.

(Rose, 1998, p.184)

Indeed, good practice guidelines stress that decisions should be made through consultation with others in the same team and managers where necessary. Further, guidelines suggest that 'Care teams should think about the way that they operate and communicate. Effective decision-making is more likely in an atmosphere of openness and transparency, where all views are welcomed and responsibility is shared' (Department of Health, 2007, p.26). However, set in the context of broader issues of change affecting the NHS (for example, cost savings); such expectations of teams may be utopian. This rhetoric may be

somewhat distanced from the actual realities of daily clinical practice, making risk management a more complex and sophisticated issue to negotiate.

Chapter Summary

As has been demonstrated in this chapter, mental health workers in this study are experiencing radical shifts in their daily practice. Narratives suggest that the climate of work is changing, both practically and symbolically. Their remit of practice is increasingly under the watchful eye of managers and their role maintained in a subordinated position through the introduction of more restricted policies and procedures. Narratives presented here highlight the departure of altruistic and benevolent aspects of their role, and the arrival of formulated, step-by-step procedural governance.

Bureaucratic control and risk management maintain close affiliation in the normative domain of mental health work. Social action of practitioners and clinicians is stringently determined by governing documents such as risk assessment tools and clinical policies. Yet, despite this (and as located in participant narratives), workers must carry individual responsibility for their decision making and provide detailed rationales for their judgements.

The motivations for adeptness in risk management techniques may be grounded in governing structures and political responses to concerns over a 'risk society'. Yet disparity emerges in the dialogue between issues of risk aversion and the therapeutic relationship or 'people work' (Goffman, 2007) that practitioners regularly undertake. Workers who are involved in the psychiatric assessment of the public are engaged in a complex scenario that appears over-weighted with concerns of governing the 'dangerous' or those who pose a threat to societal norms. This concern is conveyed through the 'numericising' (Seddon, 2008) of paper documents and risk assessment tools. The concerns which are raised here by participants indicates that there may be potential for individualised

approaches to be diluted as a consequence of governance taking place at a distance, and therefore not necessarily representing practical needs.

For many in this study, organisational change is encompassing their field of work. Systems of governance appear to be a source of conflict between organisational objectives and staff-side. The disjuncture of rule setting and practical administration of the rules has emerged as a dominant theme. The application of stricter legislation and policy (for example, Mental Health Act 2007, Smoking Ban) necessitates workers to be ever-more flexible in their approach to situations, and be resilient to the consequences of doing so whilst also questioning the rationality of such mandates.

A mental health workers' role-set may be observed as becoming more aligned with that of a street-level bureaucrat (Lipsky, 2010) rather than the tradition imagery of the caring professions. Where clinical staff are obliged to integrate these introductions of paper-based governance into their role, the character of some of them (for example, Smoking Ban) has the tendency to further tip the balance of their role into one which is more coercive than caring.

CHAPTER 6

GETTING THE JOB DONE - THE RIGHT WAY; **COMPETENCE & MORALITY IN MENTAL HEALTH** **WORK**

Clinically I'm in quite a good position to be able to do all those things that inspire confidence in those who I work with.

(Occupational Therapist Gannon; Avon Occupational Therapy Service)

This chapter examines the normative orders of occupational competence and morality within the environments of hospital based care and less restrictive environment of the Crisis Resolution Home Treatment (CRHT) team. Importantly, this chapter, drawn from the interviews provided by participants, constructs these understandings within the context of occupational cultures. An insight will be provided into some of the characteristics of these cultures, their formation, and their sustainability in the broader work environment.

Occupational cultures emerge as an important lens by which a clearer understanding of the complexities and nuances of mental health work can be achieved. It is shown in this chapter, that occupational competence maintains close links with the dynamics of these occupational groups. The rites, rituals and attitudes expose differentiation between occupational cultures (Trice, 1984), allowing their position within the organisational context to emerge. Peer regard, occupational effectiveness and attitudes towards work are thus embedded within the value/belief structure of these cultural groups and the formulation of informal norms of work. Integration into these cultural groups is not easy, and workers will endure persistent demands and expectations on their occupational presentation, performance and personal emotions.

Emotion and the management of emotion have been comprehensively developed in several sociological fields. Hochschild's (1983) concept of emotional labour and the commercialisation of human feeling have been successfully applied to a

variety of occupations including prison work (Crawley, 2004) and the general healthcare setting (see, for example, Smith, 1988;1992; James, 1992; Frogatt, 1998; Bolton, 2001; Henderson, 2001; Sayre, 2001; Mitchell and Smith, 2003). The application of an emotional labour perspective to mental health work is limited, but has been correlated to levels of stress amongst in-patient psychiatric nursing staff (Mann and Cowburn, 2005).

This chapter develops concepts of emotional labour in this under-developed area of work and practice. In doing so, it broadens upon the literature to suggest that workers are not just meeting with organisational expectations and ‘rules of feeling’ (commercialisation of human feeling), but are also subjected to expectations from occupational (sub)cultures in their management of emotion. A worker’s success or failure at managing their feelings and emotions in the view of both parties (organisation and occupational subcultures) simultaneously therefore becomes concurrent with views held on occupational competence.

An exploration of the ways in which competence is constructed takes place within this chapter. It highlights differences in competence expectations, not least through occupational speciality and the environment in which work is conducted (for example, hospital and community). In addition to this, narratives provide evidence of situations where some staff meet with competence demands and others transgress them.

This broad aim of the first part of this chapter is to examine how workers experience their work in terms of emotional expectations. To do so part one explores:

- The structure and variance of occupational subcultures
- The emotional expectations of the organisation
- The emotional expectations that informal cultures demand of workers

Part two of this chapter explores how workers interpret their work from a moralistic standpoint by investigating:

- Personal observations of the moral value of the occupational role.

- Attitudes to practice

Part One: Competence

‘There’s no ‘I’ in Team’; Socialisation and the cultural dimensions of mental health work

Goffman, (2007) writes extensively on the totalistic features of hospital life, yet the nature of the ‘total institution’ is changing. Its influence is not just confined to the hospital setting, but rather becomes an integral component in the lives of the CRHT practitioner. Their close involvement within in-patient services (for example, facilitating early discharges, care planning) and systems of governance which oversee both hospital and community clinical environments attracts this influence also.

Particular attitudes, behaviours and the outlook on the social world of work can be collective or exist in isolation. There can be several variations of a common theme (for example, morale) and conflict can arise between groups holding opposing beliefs and values. Some occupational cultures will mesh and match with organisational imperatives, where-as others can be regarded as a counter-culture in opposition to the organisational culture. These occupational subcultures, as they can be known, feature within most organisations of any size. Larger organisations give way to the potential for larger collective groupings, or an increased diversity of beliefs and values. Occupational subcultures are not just determined by the members within them; they are influenced by external factors and are shaped by responses to these. Much in the same way that all types of work and occupational subcultures are influenced by organisational objectives, mental health work and therefore the character of occupational subcultures are determined by the nature of the ‘total institution’ (for example, controls on service users, hierarchy, batch living alongside service users, threats to the self) and mandated organisational goals.

Contemporary mental health work, both institutional and within the community, may be likened to the totalistic features and be subject to the social influences that Goffman (2007) develops in *Asylums*. The multiplicity and character of the 'total institution' has the capability to project negative experience upon the worker. Occupational subcultures therefore become resonant as a line of adaptation to attempt to suppress these impacts emerging from the 'total institution'. Employees may find that membership within one or more of these occupational subcultures offer a level of stability in the face of adversity (within the organisation) and 'antagonism from outside groups' (senior managers, executives) (Barton, 2003, p.353). Workers are forced to endure and adapt within such an environment, and the subcultural group provides opportunities for collective measures to self protect against possible assaults on their concept of self. However, such measures adopted by individuals and collectively within a subcultural may well attract undue criticism as these behaviours may deviate from the 'norm' considerably (Bahn, 1995). Conversely, the utility of this constructed and collective concept of self and repertoire of manageable fronts (Goffman, 1959) may reduce the level of vulnerability emerging from extraordinary social events and arrangements, thus insulating against possible occupation-based social contaminants.

Both within in-patient services and community teams, a variety of occupational subcultures exist at Hollybrook hospital. Fundamentally, most of the collectively held beliefs are in response to their occupational duties and so exist in a pocketed manner within each ward, team or area. As Trice (1993, p.38) explains, 'as members of occupations become integrated into their cultures, they increasingly take one another as the main points of reference'. However, whilst socialisation into particular subcultural groups may mainly take place amongst immediate colleagues, several other variations are evident. Family ties, length of service, sex and occupational rank also play a significant role in determining occupational subcultures. Staff may also belong to more than one, and more than one may exist within one work area, however, the dominant subcultures are those that are formed in response to their respective occupational expertise.

Informal norms that are constructed within the occupational subcultures differ greatly, however, especially within the ward environment; there is consensus on one particular issue - competence. Peer regard and competence are assessed by the degree to which an individual staff member supports other staff. Such support and solidarity 'may help them to exercise some control, or management of the demands which they face' (Huxley, Evans, Gately, Webber, Mears, Pajak, Kendall, Medina and Katona, 2005, p.1076).

One particular example of this is when there may be risk confronting the work team. The preoccupation with danger and daily risks of violent or abusive outbursts directed at staff are seen to demand occupational solidarity and a universal response. On an acute admission ward at Hollybrook hospital, five to six staff will work on a day shift. At night, the number of staff reduces to three. There may be up to twenty service users receiving assessment and treatment at one time, reflecting that staff are significantly outnumbered. This prospect of being outnumbered by service users reflects considerable focus upon the cohesive integrity of the staff unit. For those working in these areas, cohesion and staff solidarity are necessary endemic values required for work to be carried out efficiently, effectively and safely. However this view is not universal, the variance in staff opinion on how best to deal with particular situations or incidents becomes more visible. In doing so, divisions emerge and a struggle becomes evident of the opposing subcultural ideologies.

A short while ago, at night time where you are more vulnerable, there were problems with a patient and I was hit in the face, and my colleague didn't come to support me. You feel quite upset and isolated and alone. Team work can fall down at times because some staff avoid situations when really you need the whole support of the team. If you haven't got that then other members of the team are put at risk.

The way things are now, things can easily tip into more aggressive situations. You need the support of your colleagues to deal with that.

(Staff Nurse Thomas; Humber Acute Ward)

These attitudes towards supporting one another in volatile situations appear rooted in the historical accounts of respondents. Staff Nurse Croall describes the subjects of teamwork and staff solidarity in her early nursing career. Staff Nurse Croall makes comparisons in determining how safe she feels whilst working, and the competence of staff in the contemporary setting when responding to a disruptive milieu:

Yes there is back-up. You now have a PET [Psychiatric Emergency Team], but they come from other wards. It depends on who you are working with as to whether your backup is there on the ward. Sometimes it is not. If you want the PET team then yes the backup is there. Backup is more formal now than it was.

Even though years ago you had less staff on the ward you seemed to have more backup. If you saw something brewing you would either phone your nursing officer and they would get people to come over to the ward for you, and sometimes that was all it needed. But it's different these days. There was definitely more of a sense of staff community. Staff were loyal to one another when I trained and after I trained. Staff always seemed to be loyal to one another. I don't think that they are now; I think a lot of staff back-bite each other, especially in the high up positions.

(Staff Nurse Croall; Humber Acute Ward)

Critical incidents occurring in ward areas put nursing staff in extremely stressful situations. They are tasked with providing a therapeutic response to the service user, but often with little opportunity to plan this response. Succinct measures are expected as set by organisational governance and policy, but the staff member (and usually the person in charge) may come under scrutiny from one or several members of staff who have opposing views on how the situation could be remedied. To further add complexity to a situation such as this, where opposing subcultural norm/value structures are at play, the representation of a subcultural group can fluctuate dependant upon shift pattern and duty allocation. Reacting in the *wrong* way, therefore has practical problems, but also potential for staff members to attract a 'spoiled identity'²⁷ (Goffman, 1963). Staff Nurse Peterley draws attention to this:

²⁷ Stigmatisation / marginalisation creating a 'spoiled identity' which prevents competent or morally trustworthy behaviour.

It's funny. You know when you are going to have a disruptive day, its not necessarily the patients, it's the people you are working with. I've stopped looking at the off duty now, if I see that I'm working with particular people I don't get on with, then I will be thinking about it up until the shift. I would say that I'm part of a clique that likes to see the job get done, and done well. Of course there are those, who me personally, and others I get on with, don't like to work alongside. We used to laugh about having an 'A' team and the 'B' team. You need to get along as you need someone you can trust to watch your back. Not that its always violent and chaotic here, but staff need to be switched on. You can tell who gets on working together 'cos they usually socialise together outside of work.

(Staff Nurse Peterley; Humber Acute Ward)

Whilst senior staff on duty may 'pull rank' on others in how they best see the solution to an incident, tensions can arise post incident. The competence of that member of staff can be further brought into question where the management of the situation is viewed as unsuccessful. There may be cases where staff or service users are injured during the events, making the incident much more serious and memorable. Discussions amongst subcultural groups about decisions that have had to be made quickly develop further and blame is often established. Denouncing colleagues and challenging their competence are just one component that highlights visible difference between attitudes to work and practice. Staff Nurse Dignan explains some differences between contemporary care and treatment and the attitudes towards work of colleagues who are nearing the end of their career in psychiatry:

I think with some of the staff that I have encountered, I find it difficult to work with them on a sort of regular basis because erm, in some ways staff, even now, some staff have very entrenched attitudes with regard to how the ward should be run, I think that to a certain extent that still exists today. Senior staff have entrenched views to what should be done, erm I think the big difference now is that they are challenged more, whereas before it was more difficult to challenge senior staff because it was seen that what he said basically, and the senior staff years ago were well in with the chief nursing officer, and it was very difficult to break through that barrier, whereas there are more meetings to discuss things. Senior staff who maybe have entrenched attitudes are challenged more

by other staff and so there is possibly more opportunity to break down and get your views heard.

(Staff Nurse Dignan; Humber Acute Ward)

Staff Nurse Dignan's account appears to highlight that divisions in staff groups are perhaps more apparent than they were once. Staff Nurse Croall's extract earlier describes loyalty as a key feature of mental health work. Yet, perhaps historically, loyalty and a unitary view of work were forced upon workers with little opportunity to oppose senior staff. As Staff Nurse Dignan describes, staff now are openly challenged on their decision-making highlighting deep divisions on how best work can be carried out.

Loyalty, trust and cohesion have been seen to be emotive components of nursing practice. The degree to which each one of these is interpreted by an individual or group structures and determines the level of perceived occupational competence. Each individual or group assesses co-workers abilities to get the job done, but in a manner which either supports or opposes the norms of practice held by them. As Bahn (1995) explains, where the subcultural norms are defined by the immediate work environment, differences in the character of subcultural groups become visible across specialities (for example, acute, psychiatric intensive care, and intensive rehabilitation). Whilst several subcultural groups may exist within one particular work area, difficulty emerges in the transfer between specialities of subcultural norms where newcomers learn by performing whatever work is required under the watchful and critical eye of older, experienced members' (Trice, 1993, p.128). Workers who move to different departments and specialities will undergo varying levels of socialisation. Depending upon what area they came from initially (for example, education, another ward, new to the hospital), will influence the initial process of socialisation that person will encounter. At this stage, established staff will begin a process of assessment. Personality, competence and previous work experience become fundamental factors in the process of enculturation. A period of 'proving' and 'fitting in' is undertaken, but difficulties can be encountered when faced with resistive occupational groups.

Narratives collected broadly allude to how this informal procedure of enculturation into a new cultural group can be problematic and awkward for new and old staff. Historical accounts have determined that gaining acceptance into a particular subcultural group was easier to navigate than perhaps now. There will be a variety of conditions that this is based upon, such as personality traits, but also several complex social structures which present obstacles. A worker's personal and occupational biography can be seen as useful or useless in the view of established subcultures. It will also enable or restrain the success of negotiating formal and informal social structures such as hierarchy and occupational groups. Staff Nurse Carrington's reflections on his own occupational mobility and socialisation describe the importance of a worker's biography some twenty-five years ago:

I drank in the comrades club and all the old charge nurses you know and all the old nursing officers they drank there and I got there cos I was an ex serviceman which I was thankful to a 3 month stint in the army when I was a boy at 16. Nonetheless, you know, I had a service record and I was accepted into those ranks so much so that after about 6 months being a charge nurse I was a nursing officer.

(Staff Nurse Carrington; Trent Intensive Rehabilitation Ward)

During the last five years at Hollybrook, a cadet nurse scheme has been planned and implemented. This was a scheme that was commonplace nationally, but gradually dissipated during the nineteen-nineties. Nurse education, at most large hospitals, took place on site. Typically, this involved an introductory course to formal nurse training (State Enrolled/State Registered Nurse) called the cadet scheme. This began at age sixteen and cadets would work and learn within the hospital environment. This not only allowed for practical learning experience, but also served to facilitate a degree of socialisation into the ward staff groups prior to nurse training. Staff Nurse Croall describes her experiences of being a cadet in the nineteen-seventies:

[As cadets] we used to work in departments such as the gymnasium, the hairdressers, patients monies, pharmacy, erm, the men used to work in

the barbers shop. We used to work in the staff clinic and cadet unit where we would distribute the dressing packs and whatever packs were required for the wards. Also we used to distribute white coats from the cadet unit for the male nurses.

Sister Buxton, who was then the Sister over the cadets, she also used to do the training for the nursing assistants who were employed, she would take them through the basic training that they needed for the wards. I attached and got lots of friends from being a cadet. And most of all you got to know the patients. There were some characters within the hospital then. From being a cadet, I went into pupil nurse training and I think being a cadet helped me. I knew the hospital, and I knew a lot of the people by then. It wasn't strange to me and I wasn't scared anymore. Obviously there were situations where you were quite scared sometimes but you always had the backup of other staff.

(Staff Nurse Croall; Humber Acute Ward)

Furthermore, Staff Nurse Tonry describes how his process of socialisation into particular work groups had been completed successfully prior to his first registered nurse position. Interestingly, Staff Nurse Tonry feels 'lucky' to have been accepted into the occupational group.

Yeah, I'm lucky really because I've worked on the unit anyway before I came here and knew the bulk of the staff. I think that helped in a way. But it's that transition from student to nurse, but there are a lot of worries and concerns when you first qualify and trying to fit into a team can be difficult. But it helped for me that I knew some of the staff, however that's not always a positive is it? Generally I think I have fitted in quite well, and I enjoy working as a nurse.

(Staff Nurse Tonry; Trent Intensive Rehabilitation Ward)

Those learners, for example cadets and pre-registration nurses, new to the hospital environment experience the socialisation process differently than those already working. Subcultural groups of staff will often compete to instil informal norms upon the newcomer under the veil of professional practice. The recruitment of a new learner or a newly qualified member of staff into a subcultural group will then assist the strength of that group (through number/membership) in influencing informal ways of working.

For those who apply for new jobs and those who have been redeployed as a result of changing organisational structures, socialisation and 'fitting in' can be challenging. Again, competencies are considered of paramount importance. Occupational Therapist Gannon describes her anxieties of starting a new position in relation to being accepted and respected:

When I first started there, it was very strange because I knew that I was filling two very big pairs of shoes in the two clinicians who had been there previously. They had really been very well established, had put in a very well established service and were very highly respected.

(Occupational Therapist Gannon; Avon Occupational Therapy Service)

Further, Staff Nurse Tonry describes how the ward staff team has developed following mandatory re-deployment:

There are still elements from where the ward evolved, when large groups of staff came from other wards to work here, they formed cliques of their own. There were a lot of people sent here when one of the acute wards shut. We have quite a mixture here; newly qualified, those who applied to work here and those who were redeployed. Its not overt stuff or hostility, but there are some visible groups in the staff team.

(Staff Nurse Tonry; Trent Intensive Rehabilitation Ward)

Trent ward, being a new service, has perhaps the most eclectic variation of occupational subcultures. Those who have worked there since the ward first opened, and those who have been redeployed to this area. To protect against vulnerability (for example, speciality, occupational experience and overall competence) and isolation, those who have been moved to this area, have maintained their original cliques and subcultural groups.

Work within the ward environment and the process of administering treatment is rarely conducted by just one member of staff alone. Teamwork and high levels of occupational competence within the team therefore come under constant scrutiny. Whilst work in the community, and the formation of norms of occupational effectiveness, hold similarities with the work in the hospital setting, the lone working aspect provides an alternative dimension to subcultural perspectives of competence and fitting-in.

Those staff working within the CRHT team, as has already been discussed in the previous chapter, manage and gate-keep hospital admissions. They also provide home treatment and facilitate early discharges from hospital. Although this service stands alone, it interacts on a regular basis with other community mental health teams also. At times there has been some role confusion of exactly what the remit of the CRHT team is. These views have developed in response to not only their changing organisational imperatives, but are considered also to emerge from the view of CRHT by other services. As a service in relative infancy, expectations of the CRHT have been considerable. Paper plans for this service spoke of radical ways of reducing hospital occupancy and treatment of the patient in the home environment (NHS Plan, 2000). The services which the CRHT does provide have met these objectives to a large extent. Concern is raised amongst CRHT practitioners that they are seen as being superior against community mental health teams. Community Specialist Practitioner Douglas describes this:

I would like to think that everybody gets on with everybody else but apparently that's not so. Some of the staff in different teams have felt that we are above ourselves or somehow special and different and erm, that we keep saying no and we are elitist and all the rest of it. That came initially as a bit of a shock to me but apparently that is the view amongst some. I hope it is not all. Since we have moved across here [onto hospital grounds] erm, I feel in time that will change because we are part of everybody else now. We are just next door and there is much more interaction, and rather than being just at the end of a telephone, you are talking through a referral. Being able to see people face to face and discuss issues is actually much easier to pop out and see someone with a care co-ordinator. I think, hopefully, the relationship will improve. So at the moment I am not quite sure [about how others see our team], I am hoping that things are better and things will get better.

(Community Specialist Practitioner Douglas; CRHT Team)

Relations and the informal divisions between the CRHT and other departments are further explained by Community Specialist Practitioner Churchill:

I think like most things, when other teams don't fully understand something; they are quite frightened of it. This means that they then

become quite critical and I think that they expect us to fix everything. When we can't do what they think we should do, then that again meets with a bit of hostility. It's really hard to then sort of work out what is it that people really think. Most people on a face to face seem to be okay, but people manage stress by being bitchy. I think that there is a lot of that in this place because we were a new team and we upset a lot of people.

(Community Specialist Practitioner Churchill; CRHT Team)

A deep division between staff groups of different specialities has appeared to hold credence when examining the experiences of CRHT workers. Parallels can be drawn here from the work of Sandiford and Seymour (2007) in identifying the dysfunction in staff communities. In reviewing the work of Elias and Scotson (1994), and placing it in the context of occupations, Sandiford and Seymour (2007, p.217) highlight that 'newcomers may find themselves identified as outsiders'. Whilst CRHT are not necessarily newcomers to the organisation, their field of work is and thus are defined as such. Some of the challenges of routine duties that the CRHT perform, and their interaction with other subcultural staff groups are exposed in this section of dialogue from Community Specialist Practitioner Cahill:

I think lately they [other services and departments] understand what our role is now and I think what comes from this is an understanding the service as a whole and understanding the role each part plays and that working together. I think when we first started as a team we were finding our feet and a lot was changing in how we were working and it was changing sort of from week to week and we didn't know what sort of role we had that created problems and I think they could see that we were aware of the changes and a lot of the time trying to catch you out.

I think as well at first a lot of the mental health teams were saying you will take away a lot of their crisis work within their role. So they felt their roles were being diluted and they were going to get all these specialist teams'; early intervention and crisis they would take all their interesting patients and they would be left with the 2 weekly depots and the stable ones, so I think there was quite a bit of animosity at first.

Going to CMHT meetings was a nightmare because you were going to get questioned, shot down in flames or something like that, but now is a lot different and I think that has been reflected in recruitment. We have had a lot of people come to work on our team from the CMHT's because they now realise what we do and what our role is. And we realise what our role is. We are able to quite assertively say look this is

what we are about. Erm I think that increased awareness by everyone has helped.

(Community Specialist Practitioner Cahill; CRHT Team)

According to Community Specialist Practitioner Cahill's account, differences between the CRHT and other services have been reconciled to some extent. The reconciliation has been seen to be underpinned by changing attitudes and understanding of occupational effectiveness. This move towards an improvement of peer regard is a product of a greater understanding of one-another's competencies as well as issues of possible resentment.

Whilst this partitioning of occupational groups has mainly been characterised by difference in speciality (for example CMHT versus CRHT), the CRHT team also exhibits a number of subcultural occupational groups. The potential for isolation may well be stronger within such a setting as the community due to regular lone working activities. Staff working on a ward are privileged to have several fellow practitioners on hand at all times, in comparison, community practitioners are likely to undertake a much larger proportion of their work alone. Concern is raised that those who deviate away from dominant occupational norms within the team, may damage the image of the team as a whole.

Some staff, one or two staff are isolated I think. I think you definitely have to be a team player here. You've ...we all really, need each other and for one or two of the staff who are much more individualistic and perhaps want to do things on their own, I think they very quickly become very isolated I think. I think you still respect them for their work and stuff but I think there is potential for them to become separated from the main group.

(Community Specialist Practitioner Douglas; CRHT Team)

Bureaucratic regulation will maintain some level of commonality between staff groups in terms of their clinical practice. Yet, the prevailing informal practices, opinions and socialisation of staff into dominant groups facilitate the possibility for separation and isolation. Flexibility to adapt to organisational and

subcultural demands emerges as a common theme. Those who interpret their work differently are often aligned to the fringes of the staff team or community.

As has been discussed earlier in this chapter, staff new to a particular team undergo varying levels of acceptance into that team. They may also become enculturated within a particular subcultural group, learning the norms, beliefs and values which they are immersed within. Community Specialist Practitioner Cahill describes some of his realities of joining the CRHT team:

One thing that I found that helps you fit in is how you do the job. But you need that flexibility to be able to fit in. Because there are always going to be cultures wherever you work and I think that was kind of what happened when I came here, there was a culture. There was a lot of staff originally from Moorcroft House [a rehabilitation service] you see so there was a culture anyway. I came in and started to fit in because I could do the job. I remember my first day just coming in and hitting the ground running. And like there was all the stuff on first day; do you want to go and do that visit I want to see him because I'd worked in the community got the skills wow you are just getting on with it. But then when it started some people started finding that a problem. Because kind of working independently and kind of just doing as I kind of used to but it didn't fit in with the team ethos that some people had that you go and check with the G grades [senior practitioners] first before you kind of wipe your arse (laughs) its just one of them. So I think that was kind of when things started to become difficult but it becomes frustrating you know that you are having your wings clipped a little bit. It is about fitting into a culture and you have to be kind of savvy to that as well. Sussing out what the culture is you know but you fit in if you do your job. Try and be an arse or your not good at your job, then it is quite difficult to fit in so I think it's a bit of both. It's about having that awareness of what a culture is, which I knew because I'd worked there as a student. It's like as a student you sort of put yourself out there and you gain a reputation when you are a student that sets you up later on.

(Community Specialist Practitioner Cahill; CRHT Team)

The intense nature of the occupational role necessitates some level of 'belongingness' (Sandiford and Seymour, 2007, p.216). Adaptation and manoeuvrability within the cultural dynamics of occupational groups appears an endeavour that staff pursue. The prospect of marginalisation is fraught with personal and organisational risks and the way in which the worker negotiates

this has considerable bearing upon peer regard and perceptions of occupational competence.

Organisational Structuring of Emotion

Emotion management can be considered as an important aspect of occupational competence. The success or failure of presenting oneself in a subjectively defined 'expected manner' can influence both organisational and occupational work relations.

Emotion within organisations is both structured and preformed on a daily basis (Crawley, 2004b). The way in which workers are tasked to present and perform to an audience of co-workers, visitors, managers and service users renders a necessary emotional response by the candidate. These emotions which are both felt and become observable are substantially shaped by the organisation through expected work performances. Within these relations, 'rules of feeling' are enforced and the worker must subscribe to acceptable occupational standards at their interface with others. At this point, the worker becomes less autonomous in how they are able to respond to particular social encounters, in favour of those outward expressions that meet with the approval of management and the higher echelons governing the organisation. Outward expressions and approved performances can take their toll upon the worker, not least in the observation of occupational stress (Mann and Cowburn, 2005).

The importance of these ascribed emotional responses rests with the workers as shop-floor representative of the whole organisation. As a public sector provider, the NHS therefore becomes accountable to the public stakeholders and the public purse. In the case of a *national* health service, a health provider to all UK residents and visitors, the employee becomes representative of an organisation which serves *all*, regardless of social or economic status of the service user. A deliberate attempt is therefore evident that in order to meet with the satisfaction of the general public, workers are mandated and trained to present themselves in

a courteous, effectual and efficient way. In doing so, emotions must be managed, and this is seldom an easy task, more often 'workers have weaker rights to courtesy than customers do' (Hochschild, 1983, p.89).

This suppression and alteration of personal emotions predominantly takes place during early contact with the organisation. For professional practitioners such as nurses and occupational therapists, university training and the incorporated practical placement into clinical areas will be the training ground for such structuring of the student's emotions. Likewise, non-professional staff, such as clinical support workers and technical instructors will encounter this through expectations and supervision with line managers and senior staff and on-the-job mandatory training. For many, emotion becomes sensitised to the organisational imperatives during this process and emotion is managed in accordance with these expectations as a requisite of the role.

Community Specialist Practitioner Douglas recalls some of the emotional expectations and rules of conduct she experienced whilst training:

One of the things that sticks out during that course was doing a therapy group, I think it was twice a week, we would all go into a room and basically do training in how a group works; what to say and how to react. That stuck out for me as sometimes it was quite tough, you almost felt you were being 'therapy'd'. But it was very, very useful because as a student I had to facilitate groups on wards with patients.

(Community Specialist Practitioner Douglas; CRHT Team)

The process of workers being 'therapy'd', as Community Specialist Practitioner Douglas describes, appears to provide an example where the worker is conscious that their behaviours and emotional responses are being altered in order for organisational imperatives to be met. For Community Specialist Practitioner Douglas, this guidance on acceptable responses is witnessed as necessary in order for success, independence and effectiveness in the clinical domain.

The expectation and demand to act appropriately, for clinicians and practitioners, is also embedded in the concept of 'professional' conduct. Formal training leading to clinical registration is underpinned by the concordance with codes of conduct of professional bodies such as the College of Occupational Therapists (COT) and the Nursing and Midwifery Council (NMC). In order to satisfy the public, employees must meet the professional expectations of this group, regardless of personal interpretation of set standards (for example, policies on best practice, evidence based practice). Whilst many of the components of being professional will be met by professional knowledge attained through learning, the nuances of acting professional are complex to negotiate. These will often be set on a micro-scale, based upon variations such as work environment, service user contact, age and sex, to name but a few.

The worker must present their image with a great deal of multiplicity. They must embrace the caring dimension of their work whilst also being responsive to situations in more restrictive contexts (for example, administration of the Mental Health Act). At all times they must be observed to act professionally and with integrity otherwise their behaviours become incompatible with the expectations of the organisation. They must also 'save face' where aspects of the delivery of care fail (for example, suicide, absconded patients, drug errors, misconduct, rumours, formal complaints) to maintain the professional frontage of the organisation and discipline as a whole. Staff Nurse Peterley illustrates this in an example she puts forward:

It was some years ago and at another hospital. I heard a story from a colleague that I worked down-south with. There was an incident where we had an epileptic patient on the ward and he had a seizure in the day room. Staff were aware of his condition and it was usually managed well with medication. On this evening, staff went to his assistance and ensured that his airway remained patent and clear. Other patients were in the day room also and they were asked to leave, some with a great deal of resentment as it interrupted EastEnders. The following night when I came into handover, it was reported that a patient who was watching the seizure had told the person with epilepsy that the staff went in and restrained him whilst having the fit- this was obviously not the case.

Now, we had to spend the next 12 hours caring for this person who had blatantly lied to the epileptic patient. It was a definite strain 'cos you are told that you have to remain professional and un-judgemental at all times, not to bear grudges or anything like that, but it's hard to bite your tongue. You just have to put these things to one side and get on with it.

(Staff Nurse Peterley; Humber Acute Ward)

Trainees to this field of practice are required to learn and maintain their behaviours and emotions in respect of the grand claims that are made to being a 'good' practitioner or worker. Formal educations focus upon the importance of a personal yet undifferentiated approach towards the patient in a manner free from personal judgements. This perhaps is an easy claim to make on paper, yet it is truly challenging to put aside personal feelings and masquerade in what is considered as an appropriate professional performance. This governance over feeling therefore becomes much more than just a change to the superficial performance, but rather an issue which has to address deep rooted emotions. Again, a further example is presented of the power which is exercised upon staff members by the organisation. Managers therefore have considerable influence in governing the personal, behavioural and emotional responses of those contracted to work for them. Managerial decisions and bureaucratic influences demand approved, consistent and effective responses by staff, not least through the masking of feeling and changing of behaviours. These alterations to how a worker responds to his/her emotions are observed by Hoschild (1983, p.89) 'as surface acting and deep acting'. Surface acting is a method adopted to seek approval and gratification from the audience (for example, clients, colleagues, managers) and deep acting refers to a process whereby the performance is managed to such an extent, that this particular management of emotion becomes usual and over-riding but requires close attention by the individual (Hochschild, 1983).

Where mental health work differs greatly from some other occupations, is the prevalence of hostility and disagreement within the social exchanges between staff and service users. Few occupations involve physical or verbal confrontations on a regular basis, and this is perhaps why, at times, it becomes

most difficult to manage feelings and, as Staff Nurse Peterley states, to 'bite your tongue'. The extent of, and the nature of the infarction upon personal emotion is dependent upon particular work areas. Generic rules of feeling are instilled through the necessity to maintain a professional face; however, the complexities of certain areas of work may involve additional effort in the adoption of acceptable feelings.

I'll never forget the day I started work in the Trust. I had all these fears and anxieties of doing the right thing on the ward, even though I'd been to look around, although I had some experience of working with general mental health problems. The ward was a totally different kettle of fish on the acute wards. The places I had worked prior to that, patients were generally settled. I look back now and some things I wouldn't tolerate now, you know like the verbal abuse from clients, at the time I just took it. I was too scared to say anything.

(Staff Nurse Tonry; Trent Intensive Rehabilitation Ward)

It appears that for Staff Nurse Tonry, work in adult acute environments and being a new employee to the hospital had necessitated a concerted effort to govern his feelings in order to present an appropriate professional persona. Managerial staff rarely are expected to undertake such a process of emotion management. Yet, subordinate staff are required to do this comprehensively as a component of daily clinical practice. Staff Nurse Tonry highlights that his feelings required the most management when moving into an acute hospital environment. For him, situations where interactions between himself and acutely unwell individuals was more challenging than his experiences beforehand. He also alludes to the challenge faced in his occupational performance being appropriate and embraced by the new environment. Staff Nurse Tonry also discusses how his emotions and behaviours towards clients has changed over time. He indicates that early in his career on this ward, he maintained adequate control over the organisational imposed rules of feeling. As time has progressed, the adoption of rules over personal feeling has become less stringent and more relaxed. This may also be purposeful as perhaps indulging in aspects of surface and deep acting may be counter-productive to the management of service users in this context. Furthermore, Staff Nurse Tonry

describes a change to his responses and a less tolerant approach to challenges to his sense of self as defined by Goffman (2007).

The adoption of prescribed emotions and responses can also be seen as assisting in maintaining a life-work balance. For Community Specialist Practitioner Watts, the suppressing and putting aside of personal emotions in favour of organisationally sanctioned ones maintains a division between work and home:

I try to as best as I can. I try not to get too emotionally involved in work. I do think 90% of my life is outside of the hospital it is a small part; you know you do have to live life and enjoy life as much as you can so actually when you are in work you are not feeling bitter. I don't leave anything of myself on the wards or in the departments at all. I guess you must do to a certain extent, but I don't think I leave much of my personal emotions at work, so it can't really affect me I don't think.

(Community Specialist Practitioner Watts; CRHT Team)

Here Community Specialist Practitioner Watts allows her own emotions to be governed by professionalism, and rules imposed on feelings embraced. For this practitioner, this method of managing emotions appears to illustrate how emotion can be managed in a rigid fashion. It appears that a process of 'normalising' work is adopted to maintain divisions. It is unclear how this is maintained consistently questioning whether the fluidity of emotion can actually remain within static arenas. It is likely that for Community Specialist Practitioner Watts, those emotions are kept in check through methods of surface acting. It appears that in this case, Community Specialist Practitioner Watts has become aware of the attempts made by the powerful institution that is the organisation to infiltrate her deep emotions. In doing so, she has become resistive to these pressures and maintains boundaries of emotion (work and home). This apparent normalisation of work in order to maintain boundaries is problematic. Such normalisation through organisational training, policy, procedures and professional expectations can be often unrealistic and difficult endeavours to undertake. In addition, normalisation can potentially depict a social situation as 'something different or less significant than it actually is' (Hutchinson, Vickers, Jackson and Wilkes, 2005, p.123). It is unlikely that her

deep emotions are totally unaffected by the processes utilised by the organisation (for example, training) to maintain a conformist workforce. Also, it may be the case that through occupational experience, that demarcation between emotions at work and home has been developed as a means of emotional survival.

Subcultural Structuring of Emotion

Mental health work can be hard physically and emotionally. Endeavours are made by staff to compensate for this by collective working practices and effective socialisation. Through common work practices, come common performances, routines and ways of presenting oneself to clients and co-workers, otherwise known as a ceremony (Trice, Belasco and Alluto, 1969). The worker becomes constrained in the expectations of the job, much further than a written job description or person specification. There is an expectation to 'mask feelings that are believed should not be displayed during particular episodes of interaction' (Boulton, 2001, p.86) and the creation of an authentic occupational charade. Emotion and performance become evident as examples of particular ceremonial responsibilities that structure perceptions and expectations of both participating role performers (Trice, Belasco and Alluto, 1969).

It has already been considered that the commercialisation of feeling (Hochschild, 1983) is of paramount importance when understanding how employees experience their work. Yet, feelings and emotions felt and expressed in the work environment are not just the synthesis of personal emotions and organisational expectations. Here, it is offered that a third dimension exists, that of the subcultural staff group constructing a tripartite structuring of emotion (see *Figure 5*).

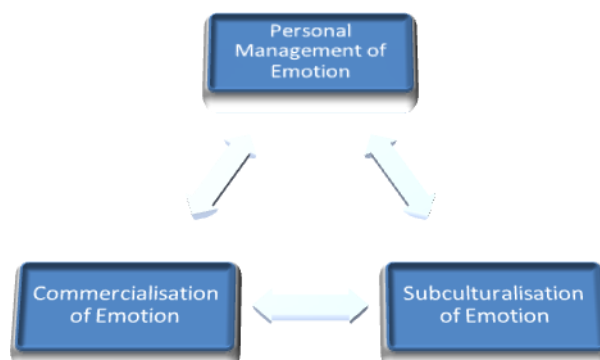


Figure 5. Tripartite structuring of emotion

It has been discussed earlier how members of staff can become embedded within particular occupational subcultures²⁸ based upon variables such as personality, speciality and competence. These subcultural groups remain fluid within the work area, however, collective beliefs on *how the job should be done* illustrate differentiation between groups. Again, it should be reaffirmed that these subcultural groups are rarely static, and that a worker may belong to more than one group or move from a situation of isolation to consolidation. Earlier in this chapter it has been suggested that common competencies can form the bedrock of a particular informal assembly of staff members.

For workers to maintain a position of informal solidarity (for example, solidarity amongst members of a subculture), they must liken their work practices to the embedded work principles of the group. Whilst this will predominantly take the visual form of action (surface acting), the employee also experiences expectations and the shaping of personal emotion (deep acting). The worker is now in a challenging situation where their personal emotional management must meet with levels of conformity expected by both the organisation and subcultural groups. The importance of appropriate ‘face work’ (Goffman, 1959)

²⁸ In this case it would be problematic to engage in a process of labeling subcultural groups specifically (as has been seen in the work of Kauffman, 1988). Those groups which do emerge can be viewed through their social status or social attachments, for example, familial connections, older staff (referred to as *tradition carriers* later in this thesis) and new staff. It would perhaps be precarious to assimilate particular staff into a particular labeled group as their ability to move outside of this is possible (through such things as shift rotation). In addition, capturing the nuances of such groups in a delineated manner would be impossible with a limited research sample and therefore any further specificity or labeling on subcultural groups is not practicable.

and performance is directed by two structures, the formal organisation, and the informal norms of occupational subcultures.

For many involved in this study, the importance of historical practices remains a salient issue in contemporary attitudes to work. Occupational norms based on traditional approaches to the work and the client group underpin expectations of performance. Approved emotional responses are embedded within the ethos of established cultural groups. Of course, counter cultures exist, yet it can be understood that those subcultural groups which hold considerable informal power in the workplace are those which have a membership that characterises work traditions of the past. These groups are often highly respected, not least for the perceived experience and wisdom of its members.

Technical Instructor Pervis reflects upon the functioning of staff teams in the hospital setting:

When you spoke to people that worked there, most had been there for more than ten years, and most for their entire nursing career, like 30 years. Everyone pretty much got on with one another. And if things kicked off, there was no question that you knew you had the support of your colleagues. There were one or two who would upset the 'apple cart' from time to time, but it seemed like there was once coherent staff culture there. Everyone knew each others strengths and weaknesses and you played the game accordingly.

There *was* gossip about some staff, but there is everywhere where you work. We used to play practical jokes on one another from time to time, and things like that kept morale up... I suppose looking back there is a sense of the 'good old days'. As well I think that there was mutual respect between wards and little resentment of one another. Nowadays you see resentment between wards usually based upon the distribution of things like staffing or types of patients that are allocated to particular areas of the hospital.

In terms of staff getting along, I think that new starters were quickly cultured into the ways of working, and those ways, because most of the staff followed them, were easy for new people to see. I just mean that the way in which you support colleagues, have a joke and maintain levels of order on the ward are educated into new starters through the process of working alongside experienced staff. It was always seen as key to maintain a low stimulus atmosphere in order for the milieu to be

settled. It could only take one or two patients to upset many, and that was very much seen as an avoidable situation to encounter.

(Technical Instructor Pervis; Avon Occupational Therapy Service)

Technical Instructor Pervis describes how new staff are ‘quickly cultured into the ways of working’. These informal practices will therefore challenge the way in which an individual will outwardly observe their work. Socialisation, dependant upon the values of a particular group, will mandate a set number of behaviours in order to maintain membership. These expectations for appropriate occupational performances will be rooted in, more often than not, an alteration to personal feelings or emotions. Occupational socialisation requires not just a prescriptive face or performance, but a much more deeply seated commitment to the norms of the group, therefore necessitating personal engagement in emotion management.

For the organisation, successful emotion management enables an overarching approach to professional and efficient care of the client. For the staff groups, successful emotion management by the employee enables a level of control in the reaction of the patient to particular circumstances (Mann and Cowburn, 2005). This becomes evident in the statements offered by Staff Nurse Rumsey:

We used to get a lot of people on the acute that would self harm and cut themselves. Anyone new to the ward we would tell “if someone cuts themselves, deal with it calmly and don’t make a fuss, just put a towel or something over it and take them to the clinic discretely”. Doing it like that can stop copy-cat incidents. What we don’t want are staff racing around in a panic. It would make us look unprofessional. Calm staff means a calm atmosphere on the unit.

(Staff Nurse Rumsey; Humber Acute Ward)

This prescriptive ‘face’ expected of staff highlights measures adopted by staff in order to maintain stable levels of social order within the wards. Personal costs of this can be high, as the expectation to act calmly and suppress personal anxiety in a spontaneous situation can be significantly challenging for those new to emotion management. Whilst the organisation expects a staff reaction as calm,

sympathetic and reassuring, the informal staff expectations would be underpinned by a need to avoid disruption to the occupational atmosphere. The management of the personal lens on emotion (Henderson, 2001), in a situation such as Staff Nurse Rumsey describes, is also a test of emotional competence to other staff. The success or 'authenticity' (Hochschild, 1983, p185) of this performance will therefore be judged by occupational peers in addition to the already established pressures of organisational conformity.

Recent changes in mental health legislation and developments in policies aimed at the inclusion of diagnoses of personality disorder have raised particular issues amongst staff groups. Prior to the latest amendment of the Mental Health Act (2007), those diagnosed primarily with a personality disorder could not be legally detained in hospital. Changes in policy and legislation have allowed for this group to now receive formal treatments and, therefore, the prevalence of patients with this diagnosis has risen within inpatient settings. The contention amongst health professionals is the ability to treat successfully disorders based on personality traits (opposed to traditional psychiatric diagnosis caused by chemical changes in the body, for example schizophrenia, bi-polar depression). Attitudes towards the treatment of such patients are diverse, primarily, those who think treatment is appropriate, and those who do not. Community Specialist Practitioner Watts describes his observation on the potential for stress and burnout in mental health work within this context:

Burn out shows itself when people can become quite disillusioned about what they do and what they can offer. You know people become very critical about the people they are looking after and the people around them and then it develops onto erm almost like erm like a chip on your shoulder. You know the prime example is with personality disorder. Amongst some staff it is a dirty word and you just need to go onto the wards and hear it mentioned in the handover and look at the responses on some of the staff faces.

(Community Specialist Practitioner Watts; CRHT Team)

The worker may be confronted with a situation where without the support of a subcultural group, they may be vulnerable within the occupational arena. Where

divisions in staff groups are based upon organisational and bureaucratic imperatives the employee may be expected to yield their personal emotions in favour of subcultural security. A disjuncture appears where, as Community Specialist Practitioner Watts has described, the attitudes towards work amongst particular employees, may not correspond with the expectations of the organisation (see *Figure 6*). To engage between outward expressions and deeply held beliefs requires complex emotion management (Hochschild, 1983, p.104). The added dimension of subcultural expectations further exacerbates the potential for stress amongst workers. The effects of this can perhaps be best seen in how emotion alters when moving away from the work environment and back into an unrestricted social zone.

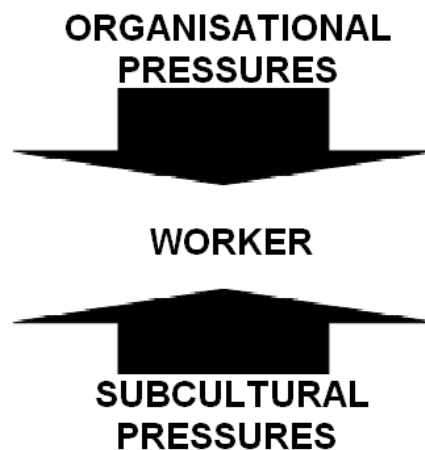


Figure 6. Compression of expectations facing mental health personnel

Community Specialist Practitioner Cahill describes the transition of emotion between work and home:

I do take work home with me I must admit I think it is easier because my partner knows the people I'm talking about so do take work home. I think it is part of the job and the personality of mental health nurses and nursing in general that you can't just switch off - it is a caring profession. There is going to be things that are emotional or prick your conscious or stuff like that and it's difficult to kind of just leave it as you walk out the door.

(Community Specialist Practitioner Cahill; CRHT Team)

Furthermore, Staff Nurse Croall states that:

I keep my work life and private life separate. I think you have to. You can't take this kind of work home with you, you have enough of it in 12 hours, and you don't want to have it at home as well. Saying that if something really bad had happened on my shift then probably yes I would take it home with me because it would be unrealistic to say I wouldn't.

(Staff Nurse Croall; Humber Acute Ward)

Staff Nurse Dignan remarks that:

Sometimes incidents happen and preoccupy me at home, but it is something I never discuss with my family and I try and sort it through myself. It can preoccupy ones mind sometimes but eventually when you revisit it and look at it again it eventually evaporates in my mind. It all depends; sometimes it takes me a while to get to sleep after shift.

(Staff Nurse Dignan; Humber Acute Ward)

In observing the pressures workers experience from co-workers, and the expectations to cultivate approved ways of feeling, the use of humour represents distinctive structuring of subcultural groups. Humour may be utilised in various ways such as; an individual mechanism of emotional support or a means by which to maintain levels of morale. In observing the use of humour, and the social areas where it is used, most participants regard humour as a facet of the 'back-stage' performance (Goffman, 1959). Here, interaction with the service users represents a 'front-stage' environment where the full repertoire of organisationally defined emotion management takes place. The 'back-stage' zone represents the social actions taking place between colleagues, in an environment such as the staff room or departmental office. Here, the expectations of emotion management are instilled in the employee in preparation for the 'shop floor' or 'front-stage' performance.

Humour represents a particular emotional response. Sharing jokes amongst co-workers is likely to be dependant upon whether or not they share a common informal cultural group. Differences in humour types (for example, gallows

humour) and the usage of humour in occupational life allows for a lens by which particular staff groups can be observed. The instances where an employee is able to share a joke of particular content with the audience can highlight divisions between subcultures. Some subcultures may adopt a particular style of humour that holds symbolic meaning to their overall attitudes to work. Technical Instructor Pervis illustrates this here:

Humour is used a lot, but I also think that OT [occupational therapy] here has had to redefine itself to meet the needs of new services and development. In light of this, new traditions have been made in place of how OT once worked. Having worked on the wards and in OT, there are stark differences in the way in which humour is used. I think the best way to describe it is that nursing humour is perhaps darker than that of the OTs here.

(Technical Instructor Pervis; Avon Occupational Therapy Service)

Here, division in humour types are highlighted. Dark humour played out in the ward environment may well be an emotional reaction to occupational pressures. Ward-based personnel are much more likely to endure regular assaults upon their sense of self (Goffman, 2007) in the form of verbal and physical assaults than therapy staff. The development of informally induced ways of dealing with that can, perhaps, be representative of this dark humour.

It is possible that subcultural staff groups maintain and develop their membership through emotional responses such as humour. Those who share the comedy value of a joke or situation become included; those who do not can be excluded. Jokes will often only be circulated amongst colleagues sharing a similar outlook on their role, where the use of humour, and at times the joke in particular, will underpin collective informal attitudes to work. The extent of collective humour and the social arenas in which it is played out, therefore represents levels of solidarity and isolation. Here, Community Specialist Practitioner Churchill describes humour usage in the CRHT team:

I would say people are often quite often raucous in this team, I've never known a team like it actually. And yes it is usually because I think that because we have been through a lot and everyone yes has giggles I said

there are about shifts I am sure there are niggles but ultimately we are very protective of one another and we manage high levels of stress and I think why then we do tend to see the funny side of things that aren't always funny. And we use that there is a lot of banter and camaraderie sort of flying around most of the time.

(Community Specialist Practitioner Churchill; CRHT Team)

Furthermore, Staff Nurse Croall adds an inpatient perspective on the use of humour and evidence that humour is shared on an informal basis, but one which is in contradiction to the organisationally expected 'professionalism':

There are also things like humour; you have got to have humour. If you didn't have humour then you would be in here yourself. It's a big part of your job. Not that you laugh at patients, you laugh at situations I think, and if you didn't do you would cry sometimes.

(Staff Nurse Croall; Humber Acute Ward)

In the same context, Community Specialist Practitioner Chapman acknowledges the potential vested interests of the use of humour in the workplace stating that '[h]umour can be used as a form of attack'.

Taking part in particular aspects of humour can play an important part in 'fitting in'. Seen as a common method of easing the stresses of the occupation, not indulging in a dominant style of humour may represent a detachment from occupational norms of that work environment. Again, the employee may have to undergo a complex re-assertion of their personal emotions and feelings in order to maintain their position within a socially secure and cohesive group.

Humour is the big one. You can walk in the office at any time and there is a lot of innuendo going on. It's like a stress relieving thing. We are close knit and work in a challenging environment. A lot of us have worked together for years and are familiar with each other and social background. We are quite open; we know each other personally and professionally, inside out. You have to trust people in this job to cover your back and work alongside you well. We live on it. If you couldn't have a laugh doing your job, you would end up admitted to hospital

(Staff Nurse Hoy; Thames Acute Ward)

We definitely use humour an awful lot. Someone who hasn't worked in this environment before may find our humour obscure. Especially the type of clients we look after and the things we deal with day to day. We don't joke behind clients backs, but generally we joke to get by. There isn't any malice or bullying in it. It improves staff morale; you would sooner see someone laughing than moaning.

(Staff Nurse Tonry; Trent Intensive Rehabilitation Ward)

Subcultural groups in the workplace may offer some solace from the potential deleterious effects of the 'total institution'. They can provide a mid-point where the worker does not need to make themselves vulnerable to the onslaught of social contaminants alone. Shared belief structures and informal practices enable a level of self protecting against these potential exposures. Yet, the practical and emotional costs of participation in such an informal group may be high. Feigning an appropriate image that corresponds with the organisational objectives has already been seen to involve a lot of personal stress (see Mann and Cowburn, 2005). Feigning an appropriate image for the benefit of subcultural membership adds additional pressures to the already complex management of personal emotion. It therefore becomes a performance in itself for workers to maintain some level of emotional equilibrium between their own personal emotions, the organisations expectations, and the demands of the subcultural groups.

Part Two: Morality

Morality and mental health care have historically has close associations. Most notably since the revolutionary approaches to the treatment of the insane by Phillipe Pinel. Pinel, working as director of the French Bicêtre Insane Asylum in the late eighteenth century sought to *unshackle* those detained in the asylums in favour of a moral approach to treatment (Rogers and Pilgrim, 2005). This moral approach involved removal of mechanical restraints, regular exercise and sunlight for patients and the introduction of assessments and therapies that involved treating the patient as an individual and looking into their personal

circumstances to consider what effects this may have on their presenting behaviours. Similarly in the UK, the York Retreat opened in 1796, again providing a stark contrast to orthodox treatments of the mad. Treatment, as Pinel had advocated in France, consisted of approaches that were based on personalised attention and benevolence towards the patient (Scull, 1979).

Drastic changes have occurred over the course of the nineteenth and twentieth century in respect of the attention towards the humane and moral treatment of the insane. Shifts in psychiatric discourses have led to what now may be considered as a compassionate and caring treatment of the insane, rather than of a penal and custodial dominance. Yet, whilst mechanical restraints are now redundant, and treatments are person centred, the remit of contemporary psychiatry continues to maintain its obligations to protect the public from potential harms.

Those working in the field of modern psychiatry are tasked with not just the assessment, care and treatment of members of the public, but are responsible also for the physical incapacitation of individuals away from the rest of society. Here, when examining levels of morality amongst staff, the tenuous balance of care and control is once again an important overtone to daily work. Moralities towards work may be constructed very differently, but will often take into consideration the employee's social learning both inside and outside of the work environment.

Findings suggest that morality within mental health work at Hollybrook hospital is two-fold. Firstly, that staff experience a feeling of moral worth and that the employee is operating in the interests of a greater public good and agents that deliver what Skolnick (1975) describes as 'puritanical morality'. Members of mental healthcare staff are entrusted with the task of managing the welfare (and at times control) of a societal group which has deviated from dominant norms. Secondly, participants demonstrate that elements of morality are integral in personal interactions and clinical practice, and their ability to convey care and treatment to infirm individuals. Both observations of morality in this context

display a common element, responsibility. Moral responsibilities are therefore in-built into the role of the mental health worker. Akerjordet and Severinsson (2004, p.169) assert that an 'emotional awareness is an important part of the moral responsibility of a psychiatric nurse... [emotional awareness] allows the mental health nurse to take care of herself/himself and the patient in a morally justifiable way'. Emotional awareness therefore can guide the behavioural outcomes of the health worker, as social encounters, in part, are informed by an employee's moral perspective and character. Moreover, abilities in the area of emotional awareness, according to Akerjordet and Severinsson (2004) are central to professional competencies.

The staff who are tasked with the detention (for example, hospitalisation) and physical control/surveillance (for example, community treatment orders) of those subject to mental health legislation become assimilated more widely with other professions safeguarding the public (for example, police constables, prison officers). In doing so, and as Herbert (1998) describes, the moralistic perceptions that are constructed surrounding the obligations of these personnel becomes enveloped in a symbolic battle of good versus evil. The state-appointed representative becomes responsible for the stability of the social milieu by enforcing statute rules and an overall concern to protect from the threat of danger.

There is little opportunity for the employee to detach themselves from this vested responsibility of control, and those who enter this particular field must abide by their professional responsibilities to maintain the safety of that person and the public. The enforcement of rules is contingent upon place, time and character, yet the worker must integrate these systems of authoritarian control into their daily care practice as and when necessary. In doing so, the rationality of the institution is upheld through what Goffman, (2007, p.80) describes as the 'moral climate of work'. Within this moralistic understanding, comes the understanding that danger, and the prospect of it, are integral components of the role. There is developed knowledge (and reinforced through mandatory training such as break-away techniques and control and restraint) present amongst

workers that there will be times when conflict arises and physical force may be required. This prospect of danger in the line of duty further reinforces the moralistic thinking that it is their responsibility alone to prevent possible harms if the service user was left uncontrolled.

I do C&R [control & restraint training] every year, I think that's just a must for the type of clients that we have here and their unpredictable nature. I know most of them are supposed to be settled on this ward, but you just never know, there is always potential there.

(Staff Nurse Tonry; Trent Intensive Rehabilitation Ward)

Furthermore, Staff Nurse Dignan explains some of the personal sacrifices this responsibility holds:

Sometimes there might have been an incident and I question whether I approached it correctly and sometimes when I finish work I don't always switch off and think that maybe I could have done something better and so it does tend to preoccupy me sometimes especially with more serious incidents.

(Staff Nurse Dignan; Humber Acute Ward)

In respect of the moral value of a caring profession, mental health work is likely to attract employees who are like-minded in this way. Support and cohesion amongst colleagues may well be deeply rooted in commonly held beliefs on the benefits their contribution to the profession brings; in addition, opinions and observations on a worker's occupational morality can be used to highlight distinctions between staff members. Community Specialist Practitioner Watts describes this comprehensively and discusses how communities of staff can be formed in light of their attitudes to practice:

There are people genuinely who want to make a difference and help people through difficult times in their life. You can have people who come to work to do their best and do their bit, but you also get people who come to work who want to you make it their world. Those who are like minded tend to stick together. There are lots of people now who can't retire because their lives have just disappeared outside of work because caring for people can be quite absorbing, it can take over everything. There are lots of relationships go on in hospitals, but that's

the way it is, you work together you sleep together you eat together and the subject matter that you talk about is quite often how your days has been, how your emotions are, what's affected them, and you talk about the day to day grind of how it is in the hospital.

(Community Specialist Practitioner Watts; CRHT Team)

Responses to those staff members who are seen to fail in their appropriate emotional awareness and do little to construct a firm moral relationship with their client are brought to light by Community Specialist Practitioner Cahill:

I struggle with certain members of staff's very negative attitudes- maybe a lack of compassion at times. That just makes it hard doing the job in general when people's judgements and that lack of compassion. I do struggle with that and it has an impact on how you do your job. You may be trying to put a care plan in place, and you get negativity in the team. It's like "hang on why are you doing that we don't need that, they just drink and are a drug user, or just a PD [personality disorder] or whatever". That's somebody mother, some brother etc... you know and it's just I struggle with that.

(Community Specialist Practitioner Cahill; CRHT Team)

It is evident from Community Specialist Practitioner Cahill's abstract above that the approach to work practices of some staff can have a detrimental effect upon not only the daily work duties, but may have potential to provoke contrasting emotional feelings (for example, frustration, anger, hatred) where moralistic attitudes to work conflict. Such conflicts are likely to be common, as the vested obligations in staff 'to maintain certain humane standards for everyone is problematic' (Goffman, 2007, p.76).

Staff Nurse Croall further illuminates her observations of moral attitudes to practice, and how these appear to have changed over her occupational career. For Staff Nurse Croall, there appears to be a distinct erosion of traditional moral attitudes in the labour market of the caring profession:

When I came in, you came in because it was a caring profession and because you wanted to do the job. The pay wasn't good, you know I started here and was on £3 a week. But I feel that the people who came

into nursing wanted to come into nursing and sometimes now some students come in because it's just a job.

(Staff Nurse Croall; Humber Acute Ward)

For some staff, their contribution to change in the practical context illuminates their personal satisfaction in the progression of services and the potential benefits to clients. Occupational Therapist Wetherby describes how her contributions at work, in her view, has influenced change more broadly:

I worked within a team with a psychologist some years ago. I was given some scope to do some work [occupational therapy] and counselling with people with learning disabilities. We used creative therapies and they'd draw upon their emotions and explored them. It was really good, I gained a lot of personal satisfaction from it, and it was similar to what mental health work is like now. It was part of trying to change the ethos of day centres – they were, it is horrible to say, just like 'bins'. People were just sort of put in a room of twenty-four people, sat around in wheelchairs looking at one another. We changed it so that everyone in a group had a valued role. It reminds me a lot of what we are trying to do now in mental health.

(Occupational Therapist Wetherby; Avon Occupational Therapy Service)

Valued contributions to the experiences of service users are viewed as personally fulfilling according to OT Wetherby. Whilst practitioners may utilise such individualistic approaches in their work daily (for example, person centred assessments), the opportunity to develop services more broadly may be limited (due to, shifts in policy and practice, political expedience, managerial influence). It is clear from this narrative that much personal and professional benefit comes from the involvement of practitioners in the process of change and the moral virtues associated in advocating social justice for those who are being cared for.

The responsibilities of mental health work can also bring admiration and respect, much in the same way other professions do where there is a risk of danger (for example, fire-fighters, coastguard, rescue services, military, policing). A name badge, or uniform in cases, provides a visual ideology and a

delineated difference between the carers and the recipients. Physical artefacts such as these serve to reinforce aspects of personal morality, importance and responsibility. Moreover, ‘when peoples’ health, safety, or welfare is highly dependent on how members of an occupation perform, members of the occupation can easily construe their work as having great social value’ (Trice, 1993, p.38). This may be further supported by external relations for example, by the support and approbation of those outside of the discipline.

Friends have always said “Christ I couldn’t do your job!” Even when I first started, people would ask questions and they are usually quite intrigued by it all and a certain fascination with the mentally ill and violence. There is a certain amount of admiration but shock as well.

(Staff Nurse Hoy; Thames Acute Ward)

Yet, the draw towards the nursing profession may be changing. As this thesis is being written, the UK is emerging from severe financial recession (as has been discussed earlier in this thesis). All of the main political parties are proposing significant public service cuts, and NHS staff redundancies have become reality in some areas of the country. As some of the narratives of participants have indicated, the moral component of nursing and allied professions draws upon applicants and workers with a particular moral disposition (for example, altruistic and benevolent tendencies). However, where a job in the NHS was once considered as a lifetime career, this may not be the case anymore. It is perhaps the case that the threat of short-term employment contracts, redundancies, retirements²⁹ and a large market of the unemployed may alter the moral character of those working in such a profession (for example, short-term employment versus vocational career).

²⁹ Chief Nursing Officer’s review of recruitment and retention of mental health nurses states that the largest proportion of working staff are over the age of fifty years.

Chapter Summary

Occupational subcultures have emerged as an important area of exploration that highlights the interface between organisational imperatives and informal norms. Competence, and interpretations of this concept, is seen as integral to the successful application of work activities. Formal rules and expectations govern the employee on a daily basis, but so too do the expectations of occupational peers and colleagues. At times, the behavioural and emotional responses of staff may be considered as subversive in comparison to those formulated by the organisation. Indeed, whilst they may conflict with organisational rules, they may actually represent practical responses to everyday situations.

The *successful* management of emotion is regarded by both organisation and occupational groups as a foundation of employee competence. Whilst there is pressure from the organisation to maintain ‘professionalism’, subcultural groups require emotional management that imbues loyalty, trust and cohesion. Employee emotions are therefore structured by both the organisation and occupational groups and the ways in which staff undertake this process can influence levels of acceptance and socialisation into work teams.

Furthermore, the moral disposition of employees is a facet of emotion management. Workers in the mental health domain administer their duties of providing care and having a responsibility for control. The nature of mental health work therefore draws a range of moralistic standpoints that range between those who have a disposition of benevolence, those who are ‘in it for the money’, those who perpetuate the hegemonic structuring of the mental health profession and those who view their work as representative of a broader social struggle between mainstream society and those who threaten it’s norms.

CHAPTER 7

OUT WITH THE OLD AND IN WITH THE NEW; THE PHYSICAL ENVIRONMENT & THE DICHOTOMY OF CARE VERSUS CONTROL

It has already been emphasised in this thesis that particular occupational subcultures may be formed on the basis of perceived occupational competencies. Furthermore, these notions, values and beliefs on occupational competence have potential to regulate the socialisation and enculturation of members of the workforce. It is not suggested that occupational subcultures are static hegemonic structures, but rather they exist fluidly, with constant revisions of their ideologies and their memberships.

This chapter explores the working cultures of Hollybrook hospital, beyond the acuity of occupational competence. It examines the authority of the physical work environment in defining particular work practices and social conduct. Moreover, in the second part of this chapter, the responsibilities of staff are presented in the context of their duty to negotiate the tenuous balance of both care and control.

Part One of this chapter aims to:

- Explore variations in work practices and attitudes to work that are influenced by the physical environment where work is conducted.
- To posit that aspects of work and the character of work is mandated by particular social phenomenon (Goffmanesque theorisations on the ‘total institution’)

Part Two of this chapter aims to:

- Develop an understanding of the nature of mental health work where daily duties are bound by the ideologically opposed administration of care and control

Part One: Physical Environment

The expectation to manage emotion effectively and appropriately has already been considered as an active component of being *seen* to be an effectual team member and clinician. The structuring of particular expectations and responsibilities emerge from both conformity to organisational standards, but also expectancy from fellow employees (and their group). The behavioural responses of the worker therefore present as a blend of expectations from the organisation and occupational peers. Organisational rules, on the other hand, remain static in the sense that they must be adhered to as a measure of employee conformity. Yet the informal rules developed, and expected, by subcultural groups, are cultivated as responses to social or organisational pressures, in particular, the physical environment where work is conducted.

In response to this, this chapter presents the points of view of a range of mental health workers from a variety of fields. Staff Nurses Weaver, Peterley, Carrington, Croall and Rumsey provide their views from an in-patient care perspective, whilst Community Specialist Practitioners Watts, Cahill, Hunt and Chapman locate environment-related perspectives within the community context. Furthermore, Occupational Therapist Gannon explains the impact of the physical environment on her work.

At the forefront of participant dialogue are two dominant themes, that of tradition and the perceived 'shelf life' of staff. These two perspectives are heavily entrenched and appear to be influenced by the physical and spatial context of contemporary work. Each, as can be seen by the segments of narrative presented, are bound up in the social ecology of the treatment environments. Since, however, the dominance of such spatial characteristics are evident in the responses of participants, then this must attract proper and appropriate sociological analysis of this domain, and the behavioural responses of those situated within it.

Working Personalities & ‘Shelf Life’

Narratives of participants suggest that staff undergo frequent and complex daily practical dilemmas (in addition to the constraints upon personal emotion discussed earlier in Chapter 6) in the course of their duty. These practical challenges may well take the form of generic duties such as paperwork and administrative roles, applicable across all clinical areas. Yet, there are particular practical tasks ascribed to particular clinical domains also, and the character of these may well be structured based upon patient treatment typologies (for example, acute assessment, intensive care or rehabilitation) and the physical environment these treatment models are allocated to. In response to these environments, staff will present and develop particular cognitive tendencies in dealing with day-to-day occurrences.

Community Specialist Practitioner Watts, now working within the CRHT team, had previously worked within a PICU environment. He introduces the perspective of ‘shelf life’, a term coined to describe the negative impact upon staff that a particular environment may have:

So I applied to Derwent ward, the psychiatric intensive care [PICU] ward after 6 months or so, on the elderly ward. I moved to my position to Derwent ward where I stayed, for I think, two and a half years. I enjoyed PICU style working but it does have a shelf life. What I mean is that you are only seeing people who are really, really ill and disturbed. Any sign of improvement and they move on.

(Community Specialist Practitioner Watts; CRHT Team)

Frustration may be apparent that staff within such an area are limited to the serious acute phase of the service user’s illness, and that recovery is rarely seen as the care process moves the individual to a different treatment environment. The restrictive nature of some physical environments, such as locked wards, is structured also with more restriction on daily activities. Rules come at the forefront of daily experience, both for the service user and staff member. As Morrison (1989, p.35) points out ‘[rules] increase the number of stressful interactions between staff members and patients and increases the opportunities

for a violent situation to occur'. Furthermore, where staff remain employed in specific clinical domains, the core purpose of a particular ward/service will govern the types, and the nature of, social intercourses for that employee, the extent of rule enforcement allocated to that area and the prevalence of rule-breaking.

For many working within inpatient services at Hollybrook hospital, their occupational roles focus upon three main areas; adult admissions (the acute phase of illness), PICU (for acute symptoms un-manageable in the adult environment) and intensive rehabilitation (recovery). Whilst all of these genres of treatment are influenced broadly by the 'total institution' (Goffman, 2007), each will conduct its work in specialised ways. These specialised ways of managing the service user legitimise the organisation (and more broadly the psychiatric profession) to implement certain practices and models for effective care and treatment. Although a service user may present certain symptoms, and a clinician's response may be constructed from this, it is also the planned and implemented responses of the organisation (for example, locked doors) that will also shape and determine the cognitive tendencies of the worker.

Goffman (2007, p107) states that staff 'personally present the demands of the institution on the inmate'. In doing so, social norms of hospital life are defined for both patient and staff. As it has already been presented by Goffman (2007), this carries much negativity, but in way of contrast, Stanton and Schwartz (1954) suggest that unstructured hospital life may be far worse for the patient (See Moos, (1974) for an overview of relevant literature). Where staff members are obliged to exert administrative practices upon service user groups (for example, restricting access to the civil life of the individual through hospitalisation) it may be the case that some staff develop behavioural responses to these dilemmas, and that they become 'tainted by the character of the work [they] perform' (Skolnick, 1975, p.54). Evidence of this is presented in Staff Nurse Weaver's extract:

It's a hard one. Working here can be difficult at the best of times. You get to a point where you are sick of saying 'no' to patients. It can get you down and at the same time you get used to it. I've seen people over my career almost get 'hardened' to their work. A whole different personality than they once had. This place can change you if you aren't careful.

(Staff Nurse Weaver; Thames Acute Ward)

The utility of Skolnick's (1975) development of a 'working personality' amongst police officers can also be applied to psychiatric professionals at Hollybrook hospital, and possibly more generally. Many similarities can be drawn from Skolnick's (1975) analysis. Mental health professionals too are positioned as ambassadors of an institution which is entrusted to protect society and in addition, to treat the mentally disordered. They work within the remittances of legislation (Mental Health Act 2007, Mental Capacity Act 2005), and during daily practice assert themselves in positions of authority over that of the patient group. Whilst Skolnick (1975) maintains that police officers are not homogenous in their approaches to work, he posits that there are 'distinctive cognitive tendencies in the police as an occupational group' (Skolnick, 1975, p.42).

Little is offered in Skolnick's (1975) analysis by way of observing difference between certain types of police work. However, in the clinical areas of Hollybrook hospital, differences across treatment domains are seen to have unique influences upon the staff working within them. In light of this, personnel will develop a series of behavioural responses that are bound by the immediate social and spatial environment which they occupy. Staff Nurse Peterley puts forward this explanation:

I've worked in a few different places; don't like to stay too long in one place. The acute [acute admission wards] are probably my favourite place to be. There is always something going on, a broad range of patients on the ward. You have your 'worried well' [neurotic disorders] and your psychotic ones, not to mention an increasing amount of PDs [personality disordered]. It's changed though, in the old hospital it was an open door policy, now they are locked all the time. Yeah, some patients have privileges set on their electronic fob to open the door,

others don't. You can feel 'hemmed' in. It seems I spend a lot more time now sorting out who can go off the ward and who can't. Yeah, locked doors, that's been a big deal on the acute for both patients and staff. We used to put people on 'obs' [therapeutic observation] when the doors were open and they were a risk of absconding; now we keep the doors shut all the time.

(Staff Nurse Peterley; Humber Acute Ward)

From Staff Nurse Peterley perspective, over his career, a move towards risk adverse practices has been seen through the permanently locked doors on the acute wards at Hollybrook hospital. Whilst some service users are assessed to be allowed to enter and leave of their own volition, containment of the remaining service users is predominantly physical. This containment, whilst some have access/exit privileges, the locked environment can be seen as symbolic of increasing discourses of control and containment. Visitors to the ward can only enter and exit with the permission and authority of a key holder, thus reinforcing the role of employee as an administrator of control. Locked environments, such as the admission wards at Hollybrook hospital, and the tightly controlled locked PICU environment whilst physically representing an apparatus of control, such environmental circumstances also serve to reinforce notions of danger.

In a climate of work such as this, precise, individual and/or collective ways of interpreting this will be constructed in the behavioural responses of the worker. Social behaviours will be contingent upon such variables as gender, experience and authority, although conflict may arise between staff where behaviours compete in the informal territory of *how best* to get the job done. Moreover, a working personality may be structured based not only upon physical measures (for example, locked doors, fenced gardens and seclusion rooms), but also as a direct response to the modality of social contaminants the worker is faced with.

It has already been considered that the element of danger manifested in the psyche of clinical staff is reinforced by physical pro-active measures (personal alarms, seclusion rooms, rapid tranquilisation protocols/equipment), but this may also may be structured by the degree of difference between the civil and occupational life of the employee. Goffman (2007) has applied such a

dimension to that of the patient, yet the worker too endures frequent social contaminations as a consequence of the people that he or she comes into contact with. The worker has little choice and is obligated to deliver treatment without discrimination or prejudice, yet by way of contrast, may be subject to verbal abuse and physical assault; things which are rarely encountered in their civil lives. As a response to this, protective measures may be assumed by staff in order to overcome these encounters such as informal work practices and sub-culturally defined occupational objectives.

In this case, it should be considered, however, that the formation of a working personality amongst staff members will be dependant upon the types of social exposure experienced or expected. It may be the case that those who work within a PICU environment come into contact with the most disturbed, chaotic and mentally unwell of all those working at Hollybrook hospital. Exposure to a sustained environment of risk may well necessitate the adoption of a working personality appropriated to that individual clinical area such as that found by Morrison (1989, p.34) where 'doing a good job means keeping patients under control'.

For those working in an admission setting the norm component and working personalities developed will differ from that of a permanently locked PICU environment. Here, working personalities will be formed, not only by the propensity to danger, but also by the high turn-over of clientele. In such a ward, staff are faced with a variety of symptoms and behaviours, however, staff have the opportunity to refer those service users expressing chaotic/aggressive behaviours to the PICU ward. Where this is the case, the severity of social assaults against staff (or contaminants) may be greatly reduced and the working personality of staff generated through imperatives less of danger, but more of efficiency.

It may also be considered that the character of particular working personalities that are ascribed to particular domains is dependant upon the extent to which 'permeability of the total institution' occurs (Goffman, 2007, p.111). The

restrictive nature of the ‘total institution’ (to both staff and service users) is likely to be at its most dominant within those environments that exert the most restrictive controls (for example, PICU). Areas such as admission wards and intensive rehabilitation, where service user access/egress is less restrictive and controls over visiting and service user possessions are less overt, the inside world of the institution blends more freely with the social standards of civil life (Goffman, 2007; Quirk *et al*, 2006). Where this less restrictive context emerges, and therefore a possible permeability of the ‘total institution’, this has capacity to alter the character of the internal workings of the environment, and in turn, to influence the components of a staff group’s working personality.

Whilst working personalities may be observed as a measure of staff self protection, it has also been witnessed by staff as a hindrance and obstacle to the autonomy and effectiveness of staff. Community Specialist Practitioner Cahill explains this further using the same terminology as Community Specialist Practitioner Watts - ‘shelf life’:

There are nurses that have worked on the same ward for 15 years and still perform to the same level- generally good and are quite happy doing that and don’t feel the need to move... But I think if you want to get on and if you want to develop and you need to move on from time to time...For me, crisis work [CRHT] keeps the stimulation going and prolongs that shelf life I think. But I think certain people and certain jobs you think yeah you have been here too long you sort of need to move on to a new challenge or something like that. I think it is a self awareness thing in knowing when that needs to be.

(Community Specialist Practitioner Cahill; CRHT Team)

Community Specialist Practitioner Cahill’s statements indicate that the immersion of staff within a particular clinical area, and specialisation with a particular clientele can leave the worker vulnerable to becoming stagnated by the influences of their environment. Additionally, the presence of staff with extended experience in particular areas are likely to be supportive of dominant informal ideologies, for example, a specified and culturally determined working personality. In a follow-up interview, Community Specialist Practitioner Watts

explains further his perspectives of the PICU environment and the staff characteristics visible at that time:

You said there is potential of a shelf life working in a PICU environment. Is that something that you have seen occurring amongst colleagues?

Yes.

And what are the effects of that?

I think, well the most common one is burn out which shows itself when people can become quite disillusioned about what they do and what they can offer. It then becomes where people become very critical about the people they are looking after and the people around them. From there it develops onto almost like a 'chip on your shoulder'... In this job [CRHT], the results are good you can pat yourself on the back when some are really, really ill. I can go home with my head held high because I've made a difference...

We see the spiky bit and we think we are the most important practitioners, but its not- it's all the rest, it's the CMHT [community mental health teams]. At times, everyone thinks they are better than one another.

(Community Specialist Practitioner Watts; CRHT Team)

Further, Community Specialist Practitioner Watts reflects on the personal effects of work within the CRHT team. The nature of the work, and also the pace of work, for Community Specialist Practitioner Watts, is seen to be embodying the development of certain feelings and behavioural responses, here, in particular, resentment:

It does worry me that it [work in CRHT] might affect my performance. I used to enjoy being a CPN [community psychiatric nurse] because of the variation and things like that. I do think working in the role that I am in at the moment is kind of 'knee jerk' work, from one crisis to another to another. I do worry sometimes that maybe in the long term my skills in certain areas might be have diminished really. I might not be as confident at running a group [for example a service user session] say than I would have been last year because you don't use you tend to forget about it. So that worries me I think...

The Crisis Team is either really really busy or really really quiet. There is no kind of days where you can just 'tick over' where you will go steadily from visit to visit, assessment to assessment. It is either ten assessments all at once and then 3 hours of twiddling your thumbs. I have never done the twiddling the thumbs thing before, I do worry it is getting me deskilled I have at times had a few hours of twiddling my thumbs then an assessment comes in, instead of getting excited about it, I have actually resented it because I have had a period of doing nothing and I thought 'ahhh I have to do something now'. You then you think 'what the hell am I doing here if I am starting to resent the work coming in what the hell is that all about?...

In the Crisis Team you have got to expect those moments of nothingness- but that does worry me, but we shall just have to wait and see what happens.

(Community Specialist Practitioner Watts; CRHT Team)

Mental health work can be viewed in two ways. Work is characterised by long periods of pedestrian activities such as; administrative procedures, making beds, tending to the personal needs of service users and dispensing medications. However, in a contrast to this, days of work are punctuated by social extremes that often arise without warning. These occurrences (for example, violent outbursts, self harm, arson attempts, absconding of service users, suicide attempts and unexpected deaths) have potential to interrupt ritualised patterns of work. Where these types of occurrences may be typical within a treatment domain, staff will take the necessary steps, both personally and collectively in order to counteract the effects of these, culminating in what is best regarded as a working personality. Behavioural responses of staff in clinical areas may be both proactive and reactive, and serve to accommodate strategies of self protection, most prominently by asserting and maintaining authority (power over service users) and leadership (structured staff solidarity).

The pace of work may also elicit the components of a working personality. As Community Specialist Practitioner Watts' narrative has shown, those employee roles where daily mandates of work are dominated by a pedestrian nature can also have an effect on the staff members' outlook on work. Environmental pressures and concerns over mundane or 'quiet' periods of work are considered to affect the skills and competence of the employee. The ways in which staff

behave and react to the modality of social contaminants, spatial pressures and the character of specific roles, become central to observations of competence, both organisationally, but equally important, on a cultural or informal level. The character of working personalities across clinical areas become visible as each will engender reactions to specific practical dilemmas, but in doing so, conflict may arise across disciplines on perspectives of *how* mental health work should be done.

Tradition, Community & Socialisation

Challenging Tradition

Hollybrook hospital; there is nothing, there is no atmosphere, there is no real atmosphere, there is no real camaraderie, it is a very sterile environment.

(Staff Nurse Carrington; Trent Intensive Rehabilitation Ward)

It has been considered that there is little evidence to suggest a consistent and homogeneous working personality within mental health work. Given environments determine how the mental health worker will respond in a particular situation, and these cognitive interpretations and responses shape their outlook on their occupational role. Whilst a broad application of a working personality (that is characterised by imminent danger, efficiency and assertion of authority much like that of the police (Skolnick, 1975)), may be applied to the psychiatric setting, variations in social environments that staff encounter further shape their cognitive propensities.

Here, a further dimension of the mental health worker's working personality is explored. Again, it is not suggested that all employees are alike, however, considerable illumination has been provided to suggest that occupational traditions are influential in determining staff's behaviours and their outlook on their work.

As has been presented earlier in this thesis, organisational and bureaucratic change and occupational responses to this have been significant themes emergent from the narratives of staff at Hollybrook hospital. These changes have been both centrally and locally driven, for example, 'Agenda for Change' job description and salary modernisation, the smoking ban and policy developments. Organisational changes at Hollybrook hospital have gained considerable momentum over the last five years, but one of the most significant changes for staff at Hollybrook hospital has been the move to purpose built accommodation from Victorian built asylum buildings. For many employees who have worked in both premises, the move to the new hospital environment was symbolic of the beginning of major revisions to the provision of mental health services locally.

The delivery of inpatient mental health services prior to 2005 was resident within a sprawling hospital site of Victorian asylum architecture. The building were characterised by large glass verandas, sash windows, enclosed gardens/recreation areas, a chapel, water tower and chimney. Like many other examples of premises built at that time, for example sanatoria and workhouses, the old hospital buildings adjacent to Hollybrook hospital represented symbolically, through their architecture, power, authority, control and a delivery of psychiatric treatment deeply rooted in its historical origins (Prior, 1988).

From the interview data collected, what appears to be clear is that staff who have worked for considerable years within the old hospital setting, look back fondly on their years working there. For many of these staff, mental health work in the new environment of Hollybrook hospital is viewed as challenging and devoid of traditional working practices maintained before the move. Conversely, staff who have experienced work primarily in the new clinical environment afford little regard to historical work practices, and are actively engaged in the development of their own strategies of practice and development of their own work traditions.

From narratives collected, division is apparent between those who have experienced work in the historical environment of psychiatry, and those who have not. Embodied within this is the view of older generations of staff who feel that historically developed, tried and tested, traditional work practices have been eroded and substituted for social and clinical practices that are unrecognisable with those utilised across their career. Goffman, (2007, p.107) refers to older staff members as ‘tradition carriers’, and this certainly appears to be the case at Hollybrook hospital. However, workers who attempt to carry the traditions of the old hospital environment are met with significant opposition and challenges that emerge from the ‘new’ and developed mental healthcare environment.

I think the happiest times were when we were the big old hospital because I think a lot of people were happy. Patients were certainly happy - most of them. Staff were happy and I feel that is a divide now amongst staff.

(Community Specialist Practitioner Hunt; CRHT Team)

These so-called *tradition carriers*, and more importantly their attitudes to work in light of their ability to ‘carry tradition’, have become an important theme in the analysis of workers contributing to this study. In exploring the perspectives of staff in this area, clear distinctions have appeared between those who are *tradition carriers* (or that attempt to) and those who are non-tradition carriers and can be regarded as a *new wave practitioner*. The complexities that each group faces in daily practice will indeed contribute to distinctive cognitive tendencies, and accordingly this may further demonstrate another dimension of the mental health worker’s working personality.

The working personality of the *new wave practitioner* is one that has been persuasively enforced upon them via institutional means and by the recent changes in mental health policy. Whilst some of the mandates and attributes that may serve to develop the working personality of a mental health worker may hold commonality, for example, assertion of authority and a prospect of danger, *new wave practitioners* are responsive to contemporary changes in the role. The working personality of the *new wave practitioner* is based on conditions of the

current organisational imperatives of being; efficient, academic, a working level bureaucrat (see Chapter 5), an advocate and a 'liberal' approach to patient care.

Recent policy developments call for improved efficiency in patient care. This not only serves to facilitate quicker recovery, but also attempts to limit unnecessary spending. Nationally, moves are being made to replace diploma level nurse training in favour of degree graduates. In addition to this, and particularly amongst the nursing profession, middle and senior positions are requesting evidence of degree and postgraduate education from applicants. Increasingly, the 'shop-floor' employee must balance their role in the provision of care and treatment and the administrative and legal governance obligations of their work. The mental health worker must also act in the capacity of service user advocate. Although a tenuous attempt to balance authoritarian and compassionate dimensions of work is present, the benevolent aspect of work is characterised by the necessity to 'sign-post' the service user to appropriate services and facilitate the active listening of the service user's 'voice' amongst the multidisciplinary team (MDT). In contrast to historical perspectives of mental health work (see Rogers and Pilgrim, 2006), contemporary care and treatment of the individual is somewhat more liberal, not least in areas of offering service users choices in their care (for example, advanced directives³⁰).

Those who are considered as *new wave practitioners* who chose to countenance these dimensions of work and be submissive and embracive of the organisational imperatives of modern psychiatry, represent a group that resides in stark contrast to those who favour, what they perceive, as traditional approaches to work. The *tradition carriers* working personality differs considerably from that of the *new wave practitioner*. A significant proportion of their personality is influenced by a resistance to new ways of working, and a cynicism towards the development/construction of new traditions and informal work practices. For some in this group, their occupational conduct may well be illustrative of being threatened by conditions of forced change in their traditions.

³⁰ Advanced directives are agreements made between service user and clinicians that outline what clinical interventions should be used if/when a recurrence of mental health symptoms occurs in the future.

The *tradition carriers'* outlook on their role is structured and embodied by the informal and formal work practices undertaken historically and prior to relocation to Hollybrook hospital. In the view of members of this group, traditional psychiatric care was influenced by; having time to be a 'people worker', experiential knowledge, delivery of care in a non-clinical environment, solidarity amongst staffing, and a conservative authority.

Prior to the advent of sophisticated and societal responsive policies on risk aversion and other administrative duties, opportunity was in abundance for clinical staff to interact with the service user population. Paperwork has already been seen as an obstacle to social relations between staff and service users (see Chapter 5), detracting from the available time that staff may engage with individuals under their care. Attempts have been made recently at Hollybrook hospital and elsewhere to provide protected therapeutic time allocation for service users. However, Community Specialist Practitioner Watts puts forward his concerns over this:

There are things that on the wards that drive me mad. When I used to work on the wards there was this thing where something called "therapeutic time" had appeared. They actually put signs up guaranteeing 30 minutes a day therapeutic time- you think 'what the hell are you doing for the other 23.5 hours of the day?' And 'when is it going to be when I need it [therapeutic time] or when you feel I need it or is it just an allotted time where I'll have to talk about all the fears and concerns I have about the world and everything in it?'

(Community Specialist Practitioner Watts; CRHT Team)

Community Specialist Practitioner Watts' concerns over the allocation and protection of staff interaction with service users clearly highlights how concerted procedural efforts are made to address the balance of time spent on administrative tasks and the therapeutic interventions with clients. Protected therapeutic time was initially advocated in a paper produced by the Department

of Health (2002)³¹. As Community Specialist Practitioner Watts' narrative extract shows, concern is raised over the rationality of such procedure. Whilst a designated time period is allotted for therapeutic time, the psycho-social nature of mental illness/distress would not necessarily fit within such strict parameters. As Community Specialist Practitioner Watts discusses, the time where a service user wants to talk and engage with staff should be set by the service user, and not confined further by the enforced routines of the institution. It is perhaps evident in this case, that whilst the introduction of 'protected therapeutic time' in theory maintains a consistent opportunity for staff-patient interactions and meaningful occupation on wards, in doing so, it represents a further contribution to a 'batch living' (Goffman, 2007) scenario and is another example of the controlling tendencies of the 'total institution's' social structure. Both parties involved (staff and service users) in this process become subject to further limitations on their daily activities. It has already been raised that service users become restricted by such a process of time allocation. For staff, the design of a procedure that advocates specific time allocations to build a therapeutic relationship with a client may well further reinforce the developing role of the practitioner as an administrator and bureaucrat and less of a 'people worker'.

Training in the Clinical Environment

A cadet nurse training scheme at Hollybrook hospital is once again being utilised as an introduction to mental health work, this, as has been seen in earlier narratives presented in this thesis, has been seen as an important introduction to the profession and the occupational environment. The value of experiential learning through socialisation into the practical environment of a ward or department is viewed as an important component of *traditional* mental health work. Staff Nurse Croall looks upon the academic nature of mental health work with some scepticism:

³¹ See, Department of Health (2002). *National Mental Health Policy Implementation Guide on Adult Acute Inpatient Care*. London: HMSO

I feel that the people who came into nursing wanted to come into nursing and sometimes now some students come in because it's a job. Because it's a degree, because it's a university qualification.

(Staff Nurse Croall; Humber Acute Ward)

The outward effects of such scepticism and attitudes of staff towards new learners embarking upon degree programmes have been observed in the workplace as Community Specialist Practitioner Chapman explains:

I watched a girl [student nurse] who would sit in the day room. It was for about a week, she would sit in the day room every day and then one day I said "who's that girl". She was a third year student [nurse] and I was appalled that none of the nurses were involving her in anything. I'm going back a few years; I felt that the nurses then that were qualified had all trained like I had, they now have got these students coming in who were now more academically trained. I don't think they felt they could teach. I think they felt that they weren't in a position to be able to teach somebody who was doing an academic qualification.

(Community Specialist Practitioner Chapman; CRHT Team)

Practical skills and experiential knowledge have been viewed as an overlooked aspect of nurse training. These skills which are gained and utilised 'on the job' have been viewed as being a neglected area of teaching and training in favour of academic achievement. Here Community Specialist Practitioner Chapman explains some of the criticisms of the Project 2000 nurse training programme which has now been discontinued:

Over the last few years its [nurse training] has got better because the number one problem was "Project 2000". I think nationally it was recognised that nurses weren't being taught properly on the wards and that they were qualifying with very little knowledge. They would have academic knowledge but no practical knowledge, no hands-on stuff. They were getting sacked; they were qualifying but then getting sacked because they were making big mistakes. I think that has come to light and there's more support from the nursing school, well it's not a school is it really? It's the University. The mentorship course is encouraging us to teach hands on with students- I feel very strongly about that.

(Community Specialist Practitioner Chapman; CRHT Team)

A great deal of importance is placed upon the environmental context of learning and mentorship in the clinical environment. When the student or cadet enters into the clinical domain, this is viewed by many as the learning sphere where class-room skills are developed. Therefore, the work environment can be considered as a domain symbolic of learning through the socialisation and instruction with co-workers and the physical and spatial social artefacts which it presents.

Environmental Change

The architectural environment of Hollybrook hospital has dramatically changed, most evident in the design of wards with single en-suite bedrooms and no designated smoking rooms. The temporal changes to the work environment are highlighted in Staff Nurse Rumsey's reaction to the new work environment:

OK, the new unit [hospital] is good in many ways, but the old place [hospital] had much more going for it. There was much more of a 'homely' feel. Corridors and rooms were carpeted. It's hard to put your finger on it really, but it wasn't so clinical. This place [Hollybrook hospital] is much more like a general hospital. There are lino floors up and down the corridors and fancy electronic locks, CCTV and electric sliding doors. It even smells like a general hospital, they must have even changed the detergent they use to mop the floors.

(Staff Nurse Rumsey; Humber Acute Ward)

Many aspects of the physical environment of the old hospital exemplify strong occupational traditions. Formal and informal working practices are adaptive to their physical constraints. For the *tradition carriers*, many favour the non-clinical environment of the old hospital buildings. The alignment of work practices into those imbued by a highly clinical environment is again illustrative of obstacles *tradition carriers* face when working in the contemporary domain. Such attitudes may be founded on the basis that mental health care is not as task orientated as general medicine, and that hospitalised service users receiving care

and treatment for mental disorders should be in surroundings that promote warmth, comfort and a 'homely' sense of feeling.

The old hospital setting, with its traditional work practices has also been seen to have maintained strong staff relations and influenced levels of camaraderie amongst staff groups. Physical representations of this can be best seen in examples such as a dedicated sports and social club, annual staff-patient holidays and facilities for Christmas extravaganzas, pantomimes and shows:

I think as well that with work having some social value to it, it made staff on a ward and between wards more cohesive. Staff did a lot for the patients and they would give their time up especially at Christmas. They used to have fancy dress parties and dances for long stay patients.

(Staff Nurse Croall; Humber Acute Ward)

Shortly after the move to Hollybrood hospital, and in response to CRES financial imperatives, some restructuring and closing of services took place. For many years, wards and departments in the old hospital environment had remained the same. Change had taken place at a very slow pace, not least through minimal central attention and spending. For many of the so-called *tradition carriers* in this study, work in the old asylum building represented stability and security, in contrast to the current unpredictability of the future of services:

Tradition has been lost, definitely. For me when the elderly ward closed, the tradition of a whole service was lost. The team was broken up; we had been together for years.

(Occupational Therapist Gannon; Avon Occupational Therapy Service)

Conservative work practices are conceivably more apparent in the history of mental health work. Service user choice is now much more at the forefront of modern mental health services³². A conservative approach to work and the

³² See for example, Department of Health (2001). *Your Guide to the NHS: getting the most from your National Health Service*. London: HMSO

unquestionable authority of the institution were legitimised and reinforced by the symbolic character of the asylum's architecture (Prior, 1988). The Victorian fascia of the asylum buildings and their grand interiors (for example, high ceilings, ball rooms and verandas) represented the authority of the psychiatric profession. Strengthened further by Crown immunity and a slow growth in patient support organisations, psychiatry and mental health care were infrequently held to public account. In contrast, modern facilities may well represent broader initiatives of community care, where short-term stays in a clinical or sanitised (of home-like or more comfortable qualities) environment are central to current policy thought.

In an environment of stability, occupational traditions and work practices can flourish. Time can be spent perfecting a role, as there is opportunity to do this. In a setting characterised by rapid shifts in economic imperatives, developing diagnoses and for-profit services, workers perhaps have little opportunity to develop new traditions but also find great difficulty in applying dominant traditions to new systems of work. The differences between those who adopt new ways of working (new wave practitioners) and those who reject them in the most part (tradition carriers) represent not only a difference in ways of working, but also a division between those new to the profession and those in the latter stages of their career.

It is not to say that all *tradition carriers* reject the new styles of work, however, what is apparent is the difficulty to continue to apply traditional work practices to new systems. This inability for *tradition carriers* to apply their own personal and developed craft of mental health work to their contemporary practice will take its toll on their outlook on their role, in turn shaping their cognitive propensities in certain situations and the development of a particular working personality.

Part Two: Care *versus* Control

Much exploration has been undertaken in determining the role conflicts of forensic nursing staff (see for example; Burrow, 1991a; 1991b; 1993a; 1993b; 1998; Mason and Mercer, 1998). Such analyses have pointed to the ways in which nursing staff working in a secure psychiatric environment undertake their role in light of the contradictory mandates of therapeutic custody. Indeed, the environmental and operational duties of forensic care differ considerably to those of general psychiatry, although the ideological dimensions of care versus control still exist.

Nursing and allied staff at Hollybrook hospital are engaged in a role of duality. In this section, views and opinions are put forward by those working within Occupational Therapy, and nursing staff. The demarcation and character of this duality are presented through the narratives of Occupational Therapist Wetherby, Technical Instructor Pervis and Staff Nurses Dignan and Weaver.

It has become apparent from the literature and interviews that, on the one hand clinical staff must administer treatments as prescribed by medical staff, maintain a benevolent and caring approach to all service users, and work as service user advocate. Yet, within the remit of such a role set, these prerequisites are set against obligated practices of control, containment and security. In a forensic context, Burrow (1991a, p.22) posits that, nursing staff are ‘professionally propelled to client empowerment... and are socially, politically and organisationally propelled to protect society’. Indeed, those working in the field of localised and general psychiatric services too endure similar occupational imperatives, albeit to a lesser extent than their forensic counterparts.

‘Good Cop – Bad Cop’

In examining the aspects of care and control in the institutional environment, it has become evident that differences have emerged between professions. The role of the ward-based nurse or support worker, and that of the occupational therapist highlight the nuances of the divergent treatment ideologies.

Occupational therapy in mental health services has its origins in the progressive moral improvements to treatments. Meaningful occupation in psychiatric settings gained greater credence throughout the early part of the twentieth century in support of developments in America. Initially, this role responsibility fell with nursing staff, however, later the role of occupational therapist assumed its own recognition in the clinical setting. Occupying the time of inpatients with structured activities is just one aspect of their role. Further, occupational therapy staff undertake assessments of cognition and physical ability in order to make contributions to the care planning of service users. Integrated within the multidisciplinary team (MDT), occupational therapists and technical instructors at Hollybrook hospital provide support and assessment in daily living activities across all wards.

The differences between the work of nursing staff and occupational therapists differ considerably. Occupational therapy staff will visit wards and engage service users in activities. These may be ward based groups (for example, a quiz), or may take place outside of the ward environment in purpose built facilities (for example, cooking, woodwork, gardening). Groups and one-to-one interventions are pre-planned and are dispersed through the working day. Occupational Therapist Wetherby identifies some of the differences between their roles:

There is a slight overlap between occupational therapy and nursing but also differences. Nurses work within a medical model whereas I am more of a functionalist. I look at what a person can do with their day, not what medications they are on and why.

(Occupational Therapist Wetherby; Avon Occupational Therapy Service)

The contrast between these two specialities becomes more apparent in the statements made by Technical Instructor Pervis. Here, the dimensions of the role set of each group are observed:

The biggest difference [between nursing staff and occupational therapy staff] is that often patients see the nursing staff as the bad cops because they hold the keys to the door and control the patient's boundaries. The OT staff come along and take patients out and do meaningful activities with them. So, often as OT staff, we don't get the verbal or physical abuse that some of the nursing staff get.

(Technical Instructor Pervis; Avon Occupational Therapy Service)

Technical Instructor Pervis' account demonstrates the practical consequences of the difference in occupational responsibilities. It appears that the visible distinction between both parties provides an opportunity for service users to air their grievances. The allocation of therapy interventions to specialised workers may be seen to repeal somewhat an important component of the therapeutic relationship between service users and nursing staff:

It is challenging to provide both care and be authoritative. It is collaboration, that's the main thing. Whenever you can get collaboration with the client, then that makes things easier. There will be times when I have to say "sorry we have to do this, this and this". But I guess being an occupational therapist I don't have to be quite as authoritative. Not in comparison to social workers who actually do the Mental Health Act or nursing staff who may, on occasion, have to say "you need this medication". I have always felt that OT's [occupational therapists] have a much nicer job in that sense, as we are usually doing stuff that the client enjoys. Authority in my work is much less of a problem for me I think.

(Occupational Therapist Wetherby; Avon Occupational Therapy Service)

The current reliance on specialist staff to engage service users in activity is perhaps consequential of time constraints on nursing staff. The provision of such expertise, whilst being beneficial to the service user, could potentially remove an important opportunity for nursing staff to engage with individuals under their care. This situation has become evident in the forensic setting also, where ‘nursing practice and comprehensive involvement in therapeutic activities has been eroded by the expanding services offered by alternative disciplines’ (Burrow, 1998, p.183).

In the broader context of contemporary care, several other occupational mandates further accentuate the disciplinary nature of nursing staff. The practical and outwardly visible aspects of delivering both care and control can be viewed on continuum. Those working in more restrictive contexts (for example, PICU), may well present an outward image that is more authoritarian than benevolent. At which point on this continuum staff are observed, will be dependent upon the character of the ward. Incidents that attract authoritative responses (for example, restraint, seclusion and enforced medicating) from nursing staff will present their profession in a particular light. Those working in a older persons’ setting, where a large proportion of their work entails personal care (for example, toileting, washing, feeding) may be viewed as caring and compassionate.

Whilst daily tasks and the character of an environment may influence the imagery of nursing staff, as practitioners they must also negotiate their own personal, practical and emotional dilemmas in relation to this. For a large proportion of personnel in the field of mental health, the challenge of reconciling their organisational mandates, occupational imagery and personal feelings is a significant challenge and staff adopt various methods to navigate this quandary:

Primarily if a patient is on a section of the Mental Health Act, then the hospital has the power to implement the requirements of that section. For example, if a patient wants to leave and they are on a section we have got to be quite authoritative and tell them that they are not able to.

Prior to that, one should, in an informal way, ask why they want to leave and just try and sort out the problem so they will stay on the ward. Hopefully they will accept informal conversations and it can be done in a therapeutic manner. If at the end of the day they are demanding to go then one has to be more authoritative and use the doctor to reinforce what is being said by nursing staff. It is a question of balance. One usually starts with a softly, softly approach and attempt to discuss things in a therapeutic way, but eventually you might have to resort to a firm authoritative stance.

(Staff Nurse Dignan; Humber Acute Ward)

However, for many of those involved in delivering mental health care, and particularly for nursing staff, the administration of authoritarian and disciplinary apparatuses is a salient and frequently used component of occupational life. The situation that nursing staff face is, that the personal and professional arbitration between ideologically opposed mandates is complex, and that organisational and bureaucratic planning can frequently push the role to that of *keeper* rather than *carer* (although it is possible that some staff may believe this is for the best) (see *Figure 7* below). In addition, political responses to what are socially defined as ‘abnormal’ or ‘problematic’ contribute to the scope of diagnosis and the breadth of services to maintain control over these populations (see for example, less restrictive definition of mental disorder introduced in the Mental Health Act (2007)).



Figure 7. Influences on the fulcrum of role duality

The opportunity for therapeutic relations to develop between nursing staff and service users appears to be becoming limited. In doing so, the care component of work retracts, and is replaced by duties of control. Whilst this is evident from the narratives of participants, similar observations have been made by the service user population in a recent Care Quality Commission Report (2010). The report highlights that ‘patient feedback to the Care Quality Commissioners in 2009/10 suggested that hospital life is becoming much more focused on rules and security’ (Care Quality Commission, 2010, p.11).

As has been discussed earlier, the removal of opportunities to build on relations, (for example, designated occupational therapy staff, gym instructors and activity co-ordinators) has potential to assert role definitions. Further, allocated ‘therapeutic time’ on wards makes the proposition that nursing staff are overwhelmed with additional duties and have little opportunity for service user relations other than at a specified time. Moreover, the implementation of legislation and policy (for example, smoking ban) has potential impact on a diluting of the benevolent aspect of work in favour of obligated restrictive and

disciplinary duties. Moreover, 'certain aspects of modern mental health nursing practice can easily result in a dysfunctional process in which interventions become limiting rather than empowering' (Sullivan, 1998, p.42). This is to say, that for nursing staff in particular, their role is structured heavily towards that of an authority figure through the developing strategies of contemporary practice.

Control and restraint plays a key role in bringing the coercive and controlling element of mental health work to the forefront. Through mandatory training, and the exercising of restraint practices upon service users, it becomes symbolic of 'the unequal distribution of power between nurse and patient, and to impede the development of a therapeutic alliance between client and professional' (Sullivan, 1998, p.43). Provocative physical interventions such as restraint further illustrate differences between in-patient staff groups, and appear to cause some contention:

It is only now, 2009, that OT's [Occupational Therapists] are getting trained in C&R [control and restraint]. They spend quite a lot of time on the ward and if it kicks off you need all available staff on hand. I think it's a good idea that they are getting trained up, you never know when you might need that extra pair of hands. I can't believe it has taken so long, I don't know why, and I don't mean this disrespectful but, maybe it's another case of "us" and "them". We all have a responsibility to get stuck in, to your colleagues and to the patients.

(Staff Nurse Weaver; Thames Acute Ward)

Divisions of labour in the management of the psychiatric patient, according to Rose (1998, p.185) previously consisted of a structure where 'diagnosis and treatment was the responsibility of the doctor, care and control was the responsibility of the nurse, and assistance was the responsibility of the social worker'. Although Rose (1998) acknowledges the changes in the multidisciplinary team approach, it appear from evidence provided in this study, that the nurse's role remains strongly situated in a obligation of care and control.

Chapter Summary

This first section of this chapter posits that workers develop particular tendencies in response to their immediate physical work environment. It applies Skolnick's (1975) theorisation of a *working personality* to the mental health field, yet its utility is limited in this area, as not all mental health professionals can be assimilated into one particular group due to the variety of contexts where work is performed. Rather, where cognitive and behavioural responses emerge, they must be situated in the context of the environment where this work is undertaken.

Changes in the physical surroundings for mental health personnel appear representative of wider changes in the profession. The move to modern hospital premises has been described throughout many of the narratives of this study. For many involved in this study, this change to the physical environment represents a marked change in how work is undertaken. The norm components of clinical practice have been altering and developing for a number of years, yet the closure of the 'old' hospital represents a much broader symbolic change to the character of psychiatric care.

An erosion of 'traditional' work practices is seen as symptomatic of the move to modern facilities. Yet, this change in the physical work environment may become the representative scapegoat for other changes such as developing educational imperatives and policy initiatives. Division between staff members is highlighted when examining the phenomena of tradition between those who advocate it and those who reject it.

The second section of this chapter has pursued a line of exploration which has emerged strongly from participant narratives, care versus control. This paradigm of contemporary psychiatric practice illustrates a radical division between occupations working in the same environment. Nurses and therapist, whilst

having common organisational goals (for example, service user recovery), are tasked with ideologically opposed remits. Professional developments in nursing have been viewed by participants to have significantly shifted towards responsibilities of control and security. This progressive ‘coercive creep’ that threatens the therapeutic aspect of their role is reinforced through policy and procedure, whilst therapy staff afford protection from administering practical measures of control. Tensions appear apparent that for mental health nursing staff, the therapeutic aspects of their role are quickly being eroded.

CHAPTER 8

NORMATIVE ORDERS: A NEW THEORETICAL FRAMEWORK FOR EXPLORING MENTAL HEALTH WORK

The multiplicity of service users within the mental healthcare system at any one time creates a significant number of dilemmas for the staff who care for them. Conversely, the multiplicity of the organisational structure places similar demands and dilemmas upon workers also. Those tasked with the care and treatment of service users face influence from both directions in the daily activity of their duties.

In this chapter, a discussion takes place which situates the research findings within a new and developed theoretical framework. It is the priority of this chapter to provide the context to the arrangement of findings and how a theoretical framework has been constructed based upon participant responses. This chapter highlights how existing theoretical perspectives and their re-development are highly germane to explorations of mental health work.

This section argues that the seminal work of Erving Goffman during the early nineteen-sixties, *Asylums*, stops short in its recognition of the extent to which his encompassing concept of the ‘total institution’ is exerted upon the *staff* who work within the contemporary psychiatric field. Much has changed in the field of mental health care since his publication, however, Goffman’s (2007) concentration of the deleterious effects of the ‘total institution’ upon the inmate perhaps overshadows some of the ‘radical shifts in moral career’ (Goffman, 2007, p.24) that contemporary staff members endure. In addition, this chapter sets out the importance and application of the concepts that Goffman (2007) develops within *Asylums* with particular attention to ‘the mortification of self’, ‘social contamination’, ‘batch living’ and ‘institutional strata’ that are observable phenomena of life within the ‘total institution’.

Through discussion of the influence of the ‘total institution’ upon occupational life of mental health workers, this thesis advocates that mental health work can be best witnessed as a series of six ‘normative orders’ whereby the syntax of formal rules and informal norms in the attainment of core occupational goals are conceptualised within a flexible framework. Drawing comparisons to the work of Goffman (2007), this thesis engages in the construction of the subjective reality of psychiatric care by the development of a normative order of mental health work. This enables a close inspection of the social world of employees in this field, unveiling aspects of consensus and conflict in response to not only organisational imperatives, but also the interwoven influences of the ‘total institution’.

The Normative Orders of Mental Health Work

Developing from the work of Herbert (1998), this thesis posits that mental health work can be witnessed as a collection of normative orders, each with particular underlying issues that influence the social order and stability of work. For Herbert (1998), organisational or occupation (sub)cultures are shaped by the elements of the normative order and this opens the analytic window into the processes of consensus and conflict within an organisation. According to Herbert (1998, p.361) the normative orders of policing ‘provide different sets of rules and practices officers use to define situations and to determine their response’.

Here, Herbert’s (1998) normative order of policing has been developed and applied to mental health work. Six normative orders have been developed from narratives provided, they are; bureaucratic control, risk management (chapter 5), competence, morality (chapter 6), physical environment and care versus control (chapter 7). These normative orders structure the social world of mental health work and are constructed to particularly highlight not only organisationally

imposed formal rules but also informal norms developed in response to them and the social environment.

The shared expectations, commitments and sentiments of dependability/loyalty which the normative orders represent govern the social situation of mental health work. Taking from the early work of Parsons (1934), where levels of consensus are met social order is maintained, Herbert's (1998) revisionist approach, and the subsequent development and application to mental health work here, highlight the areas of potential conflict within the normative order structure of work. These conflicts, therefore, have the capacity to break down the level of social order within the occupational group, the consequences of which have been presented in this thesis.

The common value or goal of mental health work is patient well-being. However, the multiplicity of circumstances, encounters and actors surrounding this vary substantially, each situation eliciting particular individual or cultural responses. The sentiments of loyalty to the organisation that workers must bear can be problematic in reconciling with themselves or others and involve both the influence of formal rules and informal norms. As Herbert (1998, p.347) describes, 'these normative orders provide [police] officers ways of understanding, enacting and valuing situations' in much the same way as nursing staff are influenced by them in the shaping of their responses to the primary value of the occupation.

Each normative order presented in this thesis represents a series of social encounters or issues which contain examples of consensus, conflict or adaptation to the core value of the job. Where this thesis differs greatly to the work of police (Herbert, 1998), is that the shared core values and the normative orders of work are heavily influenced by the symbolic structure and meaning of the 'total institution'. At times, the normative orders of mental health work (particularly those related to bureaucratic control, physical environment and care versus control) mirror many of the exerting pressures of the 'total institution'. The influences of these embedded principles are common examples

of situations where staff are engaged in particular emotional and behavioural responses in order to meet the demands of the occupation.

The worker, who at best, attempts to maintain some equilibrium to the social order of their work, is centrally positioned by exerting forces of institutional pressures, but also by normative orders which either enable or constrain their practice and/or their outlook on their role. A framework of interpretation has been developed here (see *Figure 8*), that illustrates the relationship between practical mandates of work and the conceptual social arrangements that further influence personnel in their work.

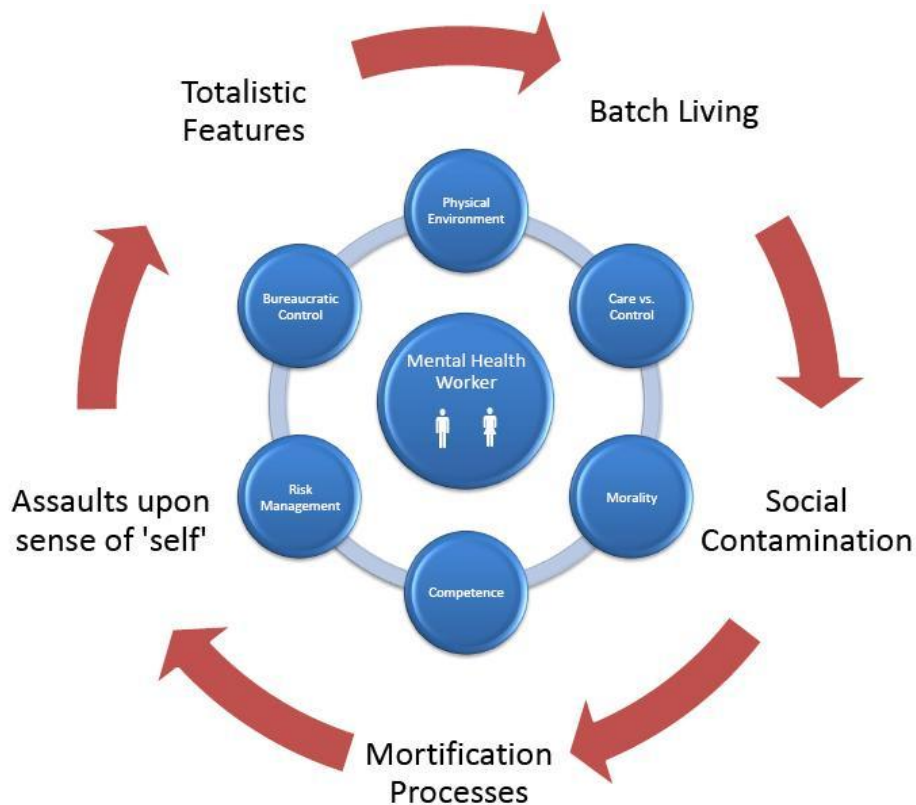


Figure 8. The normative orders of mental health work

Staff must not only struggle to come to terms with the contents of these six normative orders, but also within the confines of institutional pressures. Both consensus and conflict with these two deterministic structures is common, and

the methods that health staff utilise to maintain social order via formal rules and informal norms in their work have been presented in previous chapters.

The Total Institution

Goffman (2007, p.15) purports that the ‘encompassing or total character [of social institutional establishments] is symbolised by the barrier of social intercourse with the outside’. For Goffman (2007), the mental asylum (and other forms such as prisons, army barracks and sanatoria) represented an epitome of governance and control over social intercourse. Through the effects of a concept of ‘total institution’, patients to these establishments undergo dramatic and sustained attacks upon their usual concepts of self. These attacks serve to facilitate obedience and attempt to build ideal models of conduct in-line with the expectations of the institution.

Goffman (2007) occupies the majority of his attention toward the onslaught that the patient to these establishments experience. A ‘mortification of self’ (Goffman, 2007, p.35) is apparent as a consequence of a withdrawal from the home world and stripping of usual social contact and social roles through the physical and social structure of the mental health asylum. Practices such as ‘batch living’³³, removing and imposing of possessions, limited visiting and an overall surveillance of behaviour by staff force the patient to adopt, adapt to and construct new imposed social arrangements in their life. According to Goffman (2007, p.31) the symbolic implications of their new social environment are more often than not incompatible with their usual concept of self and force the individual into a situation of ‘contaminative exposure’. This contaminative exposure within the ‘total institution’ is primarily delivered via institutional and structural imperatives, but also operationally by nursing and allied staff and may be physical, emotional and psychological contaminations. Sustained contaminations of the self, via unusual and enforced social encounters within

³³ See literature review for a detailed description of this concept

the institutional environment, degrade the usual insulating abilities that the patient may once have maintained.

Goffman (2007) pays some limited attention towards the plight of staff working within a 'total institution' environment. Importantly, Goffman (2007, p.73) introduces the perspective of 'people work' (see Chapter 5) and the special delineation between working with human beings and working with inanimate objects. Also, Goffman (2007, p.73) acknowledges that there may well be differences between 'what the staff do in the institution in comparison to what officials say that it must do'. The disjuncture that forms around 'humane standards and institutional efficiency' (Goffman, 2007, p.76) is noted as a significant dilemma effecting staff in an environment where the requirements of 'people work' defines the daily duties of all staff.

The physical environment, the societal ethos of treatment of the psychiatric patient, the bureaucratic organisational imperatives and the staff that work within the hospital are all part of the 'total institution' scenario which the patient experiences. However, these can all be regarded as fluid, and as society and medicine develops over time, significant changes will be apparent in contrast to the work completed by Goffman during the mid twentieth century. Yet many aspects of Goffman's (2007) work have maintained their importance in contemporary sociological debates, and have been considered as influential in the programme of deinstitutionalisation (Scull, 1984) and modernisation of mental health provision.

It is without doubt that Goffman (2007) has produced a highly sophisticated and complex insight into the effects of the 'total institution' upon those who are resident within it. What is also clear is the fact that patients, as a group, endure the process of mortification of self to the greatest extent through a manipulation of residents in the interests of the institution and staff. This is prominent as it is the staff who are allowed to exit the institutional environment and maintain their social intercourse with their home world. However, as has been seen throughout this thesis, the impact that the 'total institution' exerts upon patients are not

merely confined to this group. Aspects of Goffman's (2007) original concept of the 'total institution' are to be found to be directly influential within the formal and informal mechanisms of mental health work.

Extending the 'Staff Perspective'

I passed the day with patients, avoiding sociable contact with the staff
and the carrying of the key

(Goffman, 2007, p.7)

Goffman (2007) aimed to provide a thorough account of the social situation of the mental health patient through an approach that listened to patients that, as he acknowledged, was biased and presented a 'partisan view' (Goffman, 2007, p.8). This perhaps reflects a reduced attention toward the social experiences of staff within the 'total institution'.

Life within the confines of a hospital ward is not easy. For service users, they are forced into a social environment whereby their civil social roles are replaced by those imposed by an unfamiliar social system. In time, these new and imposed social expectations of obedience are adopted (although resistance is a possibility) and personal adaptations made in a variety of ways to ease the pressures of the environment. Whilst it may be considered that nursing staff are the purveyors of measures of control, they too are subject to strict control, and to a large extent, forced to reconcile attacks on their own concept of self from the structure they work within.

It has been seen that both categories, patients and staff, must manage their own detention within the environment, encountering personal, operational and bureaucratic obstacles, albeit in different ways. Staff, like patients, are 'routine-ised' by regimes, and both are held to account where fractures or alterations occur in the mechanistic timetable of daily life. Routines and regimes are an example of the imposed arrangements placed upon each group. Staff too will navigate certain lines of adaptation (for example, emotion management- Chapter

6, resistance or ascribing to new work traditions- Chapter 7, and subcultural socialisation) in order to suppress the perceived negative impact of institutional work and become impervious to the assaults of the 'total institution' (Goffman, 2007, p.65).

Nursing staff, like prison staff, are organised and characterised by constraining and specific rules, defined areas of competency and standards of performance which see to the effective execution of routine procedures (Sykes, 1958). Face-to-face, patients are obvious recipients of measures of social control delivered by staff members within their normative structures of work; however, nursing staff are just a small part of administrative power, placed in the main for the purposes of the attainment of goals of the organisation and of the state. Staff too experience overwhelming pressures from the bureaucratic hierarchy overseeing them who, overall, maintain governance over life for staff and patients within a 'total institution' (see Chapter 5).

- **Batch Living**

Institutional mental health work has long adopted twelve hour shift systems, underpinned by continuity of care for the patient. Over-time, extra duties, weekend working, accruing time off in lieu (TOIL) and double-shifts are to a large extent common practice in the mental health field. Problems of recruitment and retention have played a considerable part in the amount of time mental health staff spend within the work environment. During the course of a twelve hour shift, workers will become assimilated into a considerable proportion of the daily routine of the ward environment; assisting patients when they wake up, three meal times, cigarette walks, medication dispensing, doctors' rounds, routine activities and assistance in preparation for bed. Workers too succumb to repeated daily and weekly routines which are usually only punctuated by extra-ordinary events. To a significant extent, and this probably goes largely un-noticed, staff too are subjected to levels of social control via these methods of routine and scheduling of behaviours achieved through bureaucratic management (McEwen, 1980).

The Mortification of Self and Social Contamination in Mental Health Work

Here, and through the narrative presented throughout this thesis, an outline is provided of how mental health staff experience assaults upon their own concept of self through the nature of the work they do. It is necessary here to remain conscious of the fact that mental health work differs considerably to other occupations such as retail, industry or administration. Few occupations share similar social and environmental pressures, except perhaps prison work (as acknowledgement of this has been afforded throughout this thesis). Indeed, perhaps the most significant of these similarities being ‘people-work’ (Goffman, 2007).

Staff too, are not immune from the intrusive exertions of the ‘total institution’, but rather endure them and adapt as patients must do using structured improvisations of human action (Herbert, 1998). Yet, staff have the opportunity to leave once they finish their duty, however, it should not be disregarded that, for many employees, they are locked within an occupation (for example, economically, prospects of job security, investment in training) and must return again and again to an environment which they will spend substantially more time than in their own home.

Goffman (2007) pays particular attention toward the contaminative exposure experienced by the mental patient. Usual environmental insulators against particular social encounters become eroded for the patient, but so too for the staff. Goffman (2007, p.32-34) purports that patients experience two main exposures to social contaminants, physical and emotional. Exposures to potentially harmful physical encounters and humiliation are common experiences for patients within the confines of the institutional structures.

However, staff experience comparable social encounters which may well impact significantly upon their sense of self and develop into a situation of dis-culturation (Goffman, 2007). As patients who enter into the ward environment

are subjected to extra-ordinary social arrangements that are diversely different to their civil ones, staff experience this diversity also (for example, encountering violence and aggression, self-harm incidents and verbal assaults). This is not to suggest that staff working within mental health care are a homogenous group, on the contrary, however, their experiences and encounters at work are likely, in the main, to be of considerable difference to those experienced in their civil lives.

The nature of these differences for staff can be stark, and so too staff can become affected substantially by exposure to social contaminants. Insulation against these can be diminished through the very character of their role, for example, responding to violence and aggression. Through their normative orders of work, staff care for clients who exhibit behaviours which directly contradict those social values which the staff member holds in their civil lives. Staff can encounter a multitude of social contaminants through their work much like the patient, where the 'total institution' operates as an agency of forced interpersonal contact.

Most notable in this study, staff have identified the challenge of balancing care with control as a significant and enduring aspect of their work. The role, at times, involves the delivery of assessment and prescribed care, but also the exercising of control upon the service user. This control can be manifested in several ways, the most provocative being physical restraint and enforced medicating. These actions by staff are commonly associated with the reaction to violent outbursts by patients and prevention of absconding. Violence and aggression in the mental health environment is common (see review of the literature), and to a much larger extent than frontline workers experience outside of their work environment. The expectations for encounters of this type are planned for, and staff are equipped to manage these incidents as a mandatory element of job training. Yet, for most staff, physical interventions such as restraint are an unpleasant and unpredictable experience and not one which is found within their normal civil lives. Where incidents and social encounters such as these are not embedded as usual occurrences in their civil lives, the

encounter at work represents symbolically a level of social contamination which is incompatible with the usual concept of self that the worker maintains. Such experiences shape and influence the normative structures of work and workers must learn to adapt and adopt precautionary principles (for example, socialisation into work groups, emotional management- Chapter 6) in order to monitor the extent to which the normative structuring of work is affected.

For workers, exposure to harmful encounters is broad within this psychiatric environment. Exposure to verbal and physical aggression, racism, sexism, homophobia and communicable diseases are endemic to the occupation. Training offers some level of insulation against these contaminants (although it also imposes strict organisationally defined emotion management- see chapter 6), in addition to the way in which staff present themselves individually and as a group (for example, show of force). Granted, these measures make some contribution against the assaults upon the 'self'; however, as has been developed in previous chapters, these measures are complex and challenging.

Goffman (2007, p32) also cites humiliation as a component of contaminative exposure. Reports from interviewees state that this humiliation can take place in several social situations, most commonly in verbal altercations between staff and patient. However, humiliation can also become apparent from the denouncing of workers either by visitors, colleagues and managers. This process of questioning professional ability takes two major forms (i) spontaneously and instantly visible during a conversation, or alternatively (ii) become apparent through systematic investigation of events where occupational errors are investigated. The former represents not only an attack upon the individual, but often upon the governance system which they are subject to. The latter, perhaps represents a level of internal humiliation within the staff strata. From an organisational viewpoint, investigation of practice by superiors ensures that work practices are compliant with expected standards, however, they too can leave the worker vulnerable to controversy and humiliation by peers and clients. This is perhaps just one example, of many, that deeper divisions within the strata of the staff group exist.

Staff Strata

Divisions amongst staff are highly prevalent amongst narratives in this thesis. Oral work histories and contemporary examples have illuminated the growing distance between front-line staff and organisational managerialism. Goffman (2007, p.110) professes that two distinctive strata exist, the ‘inmates and the staff’. Though this may have once been the case, evidence presented in this thesis from front-line staff groups, purports that in fact the notion of strata’s extends further to split the staff group in two. Front-line staff and executive organisational management appear to share little mutual exclusivity in the context of mental health work and these divisions appear to exist predominantly in ‘back-stage’ environments, out of view of the service user population.

Organisational structures have been re-designed (see Chapter 1), and in doing so, represent a deliberate reaction to contemporary organisational imperatives. Lines of management replace traditional professionally registered (for example, nurse) staff members. This new breed of leadership is heavily influenced from areas of industry and commerce in order to achieve key financial, strategic and developmental goals. In doing so, the familiarity of these new organisational practices and processes is significantly removed from the role set of frontline staff with its origins firmly rooted in ‘people work’ (Goffman, 2007).

Narratives provided by participants have provided accounts of changes in the relationship between worker and manager. Participants claim that traditional linear hierarchical structures are now devoid of any recognition. Where the line of responsibility once led to the Nursing Officer, Matron or Chief ‘Male’ Nurse, the managerial hierarchy has become more complex, interwoven and for some, distinctly amorphous. This change, from a frontline worker perspective, has emerged as a sizable challenge for nursing and allied staff, yet, one which workers must manage as a consequence of their occupational membership.

Yet, this development of complex management units serves to function as safeguards to quality and in response to centrally imposed targets and imperatives. Clinical, managerial and governance specialities are integral to the construction of modern healthcare management systems. However, the expansion of manager posts at times where there are sizable pressures on front-line services and staffing is echoed throughout the interview accounts.

Visibility of the managerial structure is also highlighted within employee narratives (see Chapter 5). Participants reflect that through the very development of such complex managerial systems, senior management have become distanced from the ward or community arena, as their remit of work is drawn more heavily towards maintaining standards of quality, improving efficiency and monitoring organisational conduct.

Symbolically this distance has grown through the physical arrangement of work and access to privileges. Service level management occupy the top floor of the hospital premises, and Trust Board executives a separate building on site. These areas are restricted by key-coded doors and entranceways where few staff are allocated access codes. Entry to these environments for hospital staff is generally only possible through invitation. These invitations may be for meetings, interviews or training purposes but are in no way a regular occurrence for many. In these circumstances, staff, like service users, (albeit not to the same extent) have their movements and access restricted also. The arrangement of management into accommodation which is physically higher than the operational facilities such as wards and clinics further reflects images of symbolic power, surveillance and the hierarchical position of governance which is held.

Distance between these two staff strata is considered by some participants to have grown. This detached relationship cannot be built solely from social encounters, but is representative as a symptom of wider bureaucratic developments. For many, the assumption is prevalent that senior management are ambassadors of the bureaucratic mechanism of work. Paperwork, on the

other hand is perhaps considered best as an aspect of the means by which front-line workers are drawn into a process of conforming to bureaucratic measures. This observable shift serves to illustrate the absorption of bureaucratic measures within an array of work domains and thus a systematic move toward Weberian theorising of an 'ideal type' bureaucracy.

Indeed, paper-work is widely known as integral to many occupations. The fact that senior managers, executives and central agencies are the manufacturers of documents (such as; risk assessments, policy initiatives and audit) plays heavy on the divisions which exist between these two staff strata. Debates between strata can become focused upon questions of 'who knows best?', thus opening potential visible and invisible conflict. Workers are requested on a regular basis to adapt their clinical and work skills in order to accommodate new forms of paperwork and bureaucracy, often with little or no consultation on their contents (for example, smoke-free policies and implementation). The processes of consultation of new frameworks of practice can be limited and frontline workers are infrequently empowered to provide advice or guidance on the operational aspects integral or pertinent to their work. Whilst managerial influence on new policy and ways of working are necessary, a lack of attention towards those who administer the contents of them contributes further to a state of disempowerment of front-line staff and a further representation (similar to how Goffman, (2007, p.104) describes the division between staff and inmate) of profoundly different human types across the staff strata's.

- **The Community & Therapy Dimension**

Collecting data from a Crisis Resolution Home Treatment (CRHT) team has provided a comparative dimension to institutional work. Physical constraints of work environments are clearly different, yet, many aspects of hospital work and the conceptual character of the 'total institution' are found within the daily practices of community based staff. The influences (such as, the mortification of self and social contamination) which Goffman (2007) positions under a banner of the 'total institution', are also evident in the less restrictive context of the

community. This suggests that, conceptually, staff do not have to be ‘locked in’ within the environment to experience similar social pressures to their hospital-based colleagues. CRHT practitioners too are positioned in roles which require them to be conversant with populations and situations detached from their civil lives whilst they operate in what has been described as ‘a ward in the community’ (Community Specialist Practitioner Wakefield, CRHT Team).

Additionally, nurse and occupational therapy training maintains a strong commitment to grounding the education of trainee practitioners within the hospital environment. Nurse training, for example, is predominantly hospital or nursing home based; this may be for many reasons such as supervision of staff in training, familiarisation with broad ranges of treatment approaches (for example, acute and chronic) or an introduction to the essence of team working. This process continues into the ‘newly qualified’ status of nursing graduates, as many NHS Trusts stipulate that roles within community-based teams require some previous experience within the hospital setting (usually 6-12 months) and preceptor-ship completion ³⁴.

Qualified staff, therefore, spend large periods of their formative career years within the hospital or institutional environment. This process of becoming enculturated into the formal rules and informal norms of the closed environment has potential for far reaching influence even where staff have left the confines of the hospital. This is not to say that all staff are alike in applying hospital learnt rules in the community setting. However, the strong influence that the institutional environment has upon the development of skills and expertise (see Chapter 7) amongst workers will undoubtedly be transferred and evident in some aspects of community work.

- **Permeability**

As Quirk *et al* (2006) put forward, mental health personnel become key agents in the permeability of the ‘total institution’ (as has been discussed in Chapter 2).

³⁴ Nursing and Midwifery Council (NMC) Good Practice Guidelines stipulate that newly-qualified nursing and midwives should undertake a period of preceptor-ship under the instruction of a mentor

They are implicit in the extent and character of assaults upon the patient population's sense of self. Yet whilst staff may regulate this for those under their care, in doing so there is a shift in attention away from the assaults upon the sense of self that also encompass staff members. Staff become semi-autonomous (for example, discretionary practices) agents in managing the practical and symbolic move from societal citizen to patient and thus can regulate the transition from civil life to, for example, hospital life. Levels of social contamination can perhaps be managed with a benevolent approach by staff members and the extent to which the patient's civil life interacts with their hospital life can be effectively planned (for example, flexible visitation arrangements, dietary requirements and possession of personal belongings).

The duty-bound professional may well facilitate such arrangements to counteract the potential deleterious effects associated with a societal individual becoming the subject of psychiatric and medical controls as a matter of routine. However, it seems apparent that whilst permeability can be regulated by staff for the benefit of service users, there is little evidence of a regulatory strategy undertaken above the shop-floor that serves to protect staff against assaults upon their sense of self. As has been indicated in earlier chapters, precautions and self-protecting measures appear to be forged within the occupational groups themselves.

Chapter Summary

This chapter has presented the core theory of this thesis. It has shown how the analysis of interview data using a thematic-based approach has afforded the construction of an analytic lens by which mental health work can be observed and better understood. The depth of expression gleaned from participants about their working lives has been arranged and structured to present a series of normative orders of mental health work. In addition to this, the physical, emotional and psychological influence of the 'total institution' upon patients and staff has been explored.

Fundamentally, this development of a core theory provides opportunity for a broader understanding of the context in which work is undertaken. In doing so, it moves away from the provision of 'snap-shot' imagery of workplace stress and staff burnout, rather it puts forward a framework that acknowledges the broad convergences of politics and the economy in clinical practice, but also explores formal organisational mandates set against informal workplace norms.

It has also been the intention here to highlight the short-comings in the attention toward nursing staff that, in comparison to patients, have remained somewhat in the shadows as far as the symbolic affects of the 'total institution' have been concerned. Integrating an acknowledgement of such social phenomena highlights the influences and challenges which staff endure daily. Indeed, within a framework such as this, there is a conscious move to explore beyond the practical issues, and to engage and apply the symbolic, ideological and conceptual relevancies of this occupational discipline.

CHAPTER 9

HOLDING THE TIGER BY THE TAIL; **CONCLUSIONS ON THE DEVELOPING ROLE OF THE** **MENTAL HEALTH WORKER**

Throughout this thesis, participants have presented their views, opinions, anxieties and grievances of their work. In gathering the oral occupational histories of staff, it has become apparent that mental health work in years gone by is looked upon with a certain degree of fondness. In contrast, the views aired by practitioners in relation to their current practice are punctuated with concerns and anxieties in the fundamental shifts that their work *has* and *is* experiencing.

This study has been conducted in an exploratory manner in order to gain subjective meanings attached to mental health work from those immersed in the field. First hand accounts of formal and informal work practices, historical accounts and occupational challenges have been provided through a three stage narrative interviewing technique and subsequent analysis. Importantly, throughout this study, attention has been paid to the informal norms of the workplace as well as those formal rules set by the organisation. At times, this often contradictory approach to work has provided the utility to get the job *done* in an environment where the modality of treatment is in a constant state of flux.

Method Evaluation

In considering earlier discussions over the use of thematic analysis (see Chapter 4), it is important to return to how the researcher has been influential in the production and/or transformation of the voice of the participant (Plummer, 1995). Thematic analysis of narrative has come under some criticism, yet the researcher has been conscious of the audience domain that the participant's voice will be projected into. As described earlier, Plummer (1995) describes

how the researcher is a key agent in the broadcast level of a story's and where it would appear within a social order of importance/recognition. Indeed, much of the narrative in this thesis displays criticism from subordinate ranks (of an occupational hierarchy) of the challenges of engaging with centrally and locally distributed policy. Therefore, it has been important to present the narratives of workers in a manner which seeks to influence readers, some of which who are in a position of seniority to those who have contributed. It was felt that a theme building approach would facilitate in this, as comparisons between various participants have been made and collectively experienced issues put forward in a clear and persuasive manner. Although representativeness is not a key concern of this study, to leave the story as a whole would have perhaps provided little opportunity to highlight substantive issues experienced by a range of practitioners and the relationship the particular issue has with the occupational world (Plummer, 1983, p.100).

The use of participant narratives have provides an insight into not only the work of mental health professionals, but also their lives more generally. As Fairbairn and Carson (2002, p.8) consider, '[m]uch of our human life is conducted through story. Many of our social institutions are comprised almost entirely of opportunities for telling and retelling stories, for sharing the narratives that constitute our lives'. The work environment of the clinician or health professional is no different, and the strength of this approach can be seen through the presentation of their responses in this thesis.

Taking the time to listen to the workers involved in this study has been fulfilling personally to the researcher, affirming some of the notions from previous occupational experience in similar areas, but also surprising, informative and emotional. It is understood that the subjective realities that have been collected, analysed and presented are limited in their generalisations across the expanse of public sector health services. Indeed, the specific content of experiences may vary considerably across disciplines and individuals, yet the themes that have developed from this study (normative orders of mental health work) have the

potential to be transferable and utilised across further fields of practice as an analytic lens.

The participant narrative has enlightened upon the social context of an occupational group not readily available to researchers, policy makers or the wider public domain. Using narrative has provided participants with an opportunity for their reflections to be made available more broadly and in such a way that makes them accessible to a wide readership. Grounding the research in the participants own terminology to the extent that narrative inquiry has facilitated, further provides illustrations of the complicated nature of their work.

Importantly, this methodology has helped demonstrate how mental health personnel develop strategies of coping and negotiation not previously applied in this area of inquiry. The use of narrative has shown in detail the extent to which an employee's formal and informal spheres of work co-mingle. Alternative methodologies would have perhaps not illuminated the broad context and background character of this profession, whereas it is hoped that readers of this thesis would agree that the employee's own narrative has brought their work to life.

Reflections on Researching Occupations

Current policy developments in the area of recruitment and retention promise to reconcile the complex nature of work with those attracted to, and already within the profession through support and encouragement in personal development. While much work is being completed in an attempt to remedy problems in workforce buoyancy, the rhetoric of such strategies are set against the organisational and practical implications of public service working in a contemporary socio-political climate. Increasing practical expectations and responsibilities are seen to be developing across many public sector areas. The NHS perhaps is just one public sector example where expectations for improved

services and technologies share the same territory as requirements to be both cost effective and efficient in an area of growing financial cuts.

While there is an abundance of research evidence to support claims that stress and burn-out are endemic within mental health professions, little was known of the multiple strategies adopted that enable employees to perform their work duties. In addition to this, this thesis has provided a picture of the effects that mental health work has on an employee's outlook on their world.

What has emerged is that despite policy and training attempting to provide resolutions to staffing crises (for example, recruitment, retention, sickness and returnee's); there are few clear-cut challenges to address. Rather, challenges are indigenous to their immediate area and dependant upon the time and character of this. Frequently, it is the rationality of the introduction of central and local policies and procedures which serve to further supplement the problematic nature of 'spinning occupational plates'. Mental health workers, therefore, are immersed within a role of multiplicity. Their role-set can increasingly become complicated, not least in this current 'era of austerity', and can quickly become hindered by governing imperatives, financial sanctions and political expedience. The practical, emotional and symbolic nature of the care professional's work now takes place within a variety of spheres, namely those of 'people work' and bureaucracy. The problems that arise from such role obligations, is that the boundaries between these occupational worlds can be lacking in clarity and definition. The mental health professional, over time, has assumed the role of purveyor of policy initiatives and thus developed their own multifaceted occupational role-set. As this role has evolved, mental health professionals are therefore thrust into an opportunistic position, as they become 'expert witness' in the consideration of the 'pros and cons' of top-down policy, procedure and protocol.

The design of this study has lent itself as employee advocate and has not viewed sub-culturally defined practices as obstacles to organisational developments. Some studies and reports would lead us to believe that the very presence of

occupational solidarity and the cultural nuances or norms of these groups in the workplace are a threat to the quality of organisational output. Yet these areas of exploration have proceeded to illuminate that they are actually an outcome of changing structures and environments that they reside within.

What has been provided, are accounts of the social experiences of mental health workers across their own careers. In doing so, those participating have been able to define their work in their own terms, addressing those issues and dilemmas which are wrangled with on a frequent basis. These accounts have been uncensored and serve to represent an accurate depiction of mental health work that has been experienced by those directly involved. The content of narratives have consisted of both broad and complex dimensions, generating content that includes and moves across boundaries of structural, organisational and emotional aspects of work.

The exploratory analysis of the asylum by Goffman (2007) presented influential evidence of the harmful effects of institutionalisation on the patient population. Much has been done to tackle these effects, not least in the significant decrease in hospital occupancy. Yet despite various developed strategies, the social and emotional influences of hospitalisation remain a salient academic and professional concern. What has appeared though is that staff too are heavily influenced by the emitting pervasive nature of such structured environments. So too, are those working outside of the restrictive context of hospital work. In particular, the assaults upon the sense of self, social contamination and aspects of batch-living all influence daily clinical practices. Staff are subordinated in their occupational role by a duality of organisational and symbolic (for example, 'total institution') dominance. In addition to this, workers are powerless against politically structured ideologies and imperatives.

In many ways, this research complements and develops those which have undertaken specific social analyses (for example, managing violence and aggression, stress, burnout and the role set of forensic nursing staff). Where this research differs considerably from those which have already examined some of

the complex issues of mental health work is in the adoption and use of narratives. Consequentially, this study has shown that the daily work of mental health staff is much more complex than perhaps other studies highlight in limiting their gaze. It provides a broad sociological perspective that develops the seminal work of Goffman (2007) in drawing more attention towards the 'staff world' in the context of the deleterious impact of the 'total institution'.

In addition to this, and drawn from the analysis of participant's dialogue, a set of 'normative orders' have been developed to provide a lens by which mental health work can be viewed. The application of normative orders of work has already been applied by Herbert (1998) to Los Angeles police officers, yet with development and the generation of themes emergent from data, the utility of this method has been witnessed and its application to the social world of the mental health worker providing a structured exploration of professions. The sociological framing of aspects of work provides some consistency in the expressed definitions in mental health work. In addition, the review and application of literature from a range of fields, such as sociology, criminology and health studies has potential to broaden understandings and explore previously invisible and under acknowledged dimensions of work.

In this thesis, workers have described their position in an evolving organisational structure. Power differentiations between those who administer practice and those who govern the environment overarch the narratives presented. Provocative changes have been witnessed by mental health workers in recent years. The dormant political and economic attention towards mental health services has been seen to have abruptly terminated and whilst services and conditions are recognised to be much improved for the service user, the developing mandates for those delivering care are intricate and involved.

Further, political and legislative introductions such as the Mental Health Act (2007), and smoke-free policies, are observed to be influential in the stability of work areas. Workers must negotiate the legal intricacies of new legislation and the practical dimensions required to administer it correctly and professionally.

In discussing further legislative introductions, great importance was placed on the effects of the introduction of a smoking ban to NHS premises. Such legislation has been observed to impact heavily on the therapeutic relationship with service users. Concern was raised that those directly involved in asserting authority over service users were placed in a position of potential danger and confrontation.

Whilst the health promotion benefits are widely understood, confiscating cigarette lighters and regulating the smoking of service users has attracted several practical problems such as assaults against staff but also a breakdown of relations between managers and front-line staff. Where many operational problems are encountered in administering such procedures, the rationality of policy has come into question. Such examples therefore require forward facing staff groups, and those directing policy and procedure, to consider proposed and current practices in light of their future impacts.

There has been a dominant concern that has emerged from interviews that policy has now replaced the autonomous nature of the mental health worker. There is a sense of feeling that they are no longer trusted to apply their experientially gained autonomy in decision making. Workers occupational lives are highly regulated by policy and procedural direction, with little opportunity for experienced staff to apply their 'craft' of care and little opportunity for new recruits to develop these. Symbolically this represents a shift away from the personal and altruistic nature of caring professions, and a move towards a structured and calculated care delivery format. The ability for employees to self-govern their immediate clinical area is becoming increasingly dissolved.

In developing a new organisational culture, staff at Hollybrook hospital fear that their future is rapidly becoming more uncertain. Fundamental aspects of their role (for example, autonomy) are becoming diluted and physical and operational changes are developing in their encompassing environments beyond their control. It is widely felt that front-line staff are becoming heavily restricted in the context of their work, exacerbating power struggles between tiers of

management and raising prospect of further occupational inequalities. Through the implementation of stricter governance in the workplace, the flexible character of the worker has diminished, thus making daily work in an interpersonal environment significantly challenging.

Theoretical Implications

It has been observed here, as elsewhere, that nurses are accomplished emotional jugglers (Bolton, 2001). Yet, they are much more than this. Whilst they manage their emotions, they must also ‘juggle’ a broad range of further formal (organisational) and informal (occupational) mandates that co-exist and form a complex invisible background (Cleary, 2004) to nursing and care delivery.

A series of existing social analyses have been drawn together in this thesis from a range of areas. In a similar vain to Crawley (2000; 2004), this study has sought to explore the utility of theoretical perspectives already established in the field of occupations (for example, Skolnick’s *working personality* and Hochschild’s *emotional labour*) in the field of mental health work. What has emerged, not least through the adoption of narrative inquiry and inductive/deductive thematic analysis, is a theoretical framework that enables a comprehensive exploration of how mental health work is done. The development and application of Herbert’s (1998) ‘normative order’ to the mental health domain has provided an ideal platform to examine the social characteristics of this clinical staff group. Fundamentally, the duality of the practitioner’s role (care and control) has become evident and an appreciation of the ‘coercive creep’ that encroaches upon the therapeutic aspect of their role has been identified. It moves beyond the original work of Herbert (1998) by providing a heuristic device to frame the complexities of ‘people work’ and draws attention towards the challenges involved in reconciling welfare (care) approaches within coercive (control) frames of action through bureaucratically sanctioned and pre-conditional autonomy.

By locating these normative orders of mental health work under the auspices of Goffmanesque theorisations (for example, the mortification of self), this study provides a broader understanding of the staff's individual, collective, formal and informal social situation.

Practical Implications

At the time of fieldwork, staff at Hollybrook hospital were receiving very little opportunity for involvement in the development of services and implementation of policy and procedure. It is therefore argued that by opening lines of communication further with those staff directly delivering services may improve this situation. The anti-bureaucracy mantra of 'the more we measure quality, the less we can provide it' is perhaps a step too far and by no means a consensus view upheld by those involved in this study. Rather, workers acknowledge the importance of quality management and protocol in their work, however, the opportunities for participation in the development and critique of such enterprises appears somewhat limited. The continuing impact of 'governance at a distance' and 'top-down' approaches is likely to remain a salient issue for many shop-floor workers into the future. In order to capture the practical effectiveness of policy and procedure, this needs the continued engagement of those who will administer it. In developing the opportunities available to staff for consultation over key service delivery decision making, senior executives will benefit from expert experiential knowledge that represents localised need.

Although it may be problematic to generate firm practical steps from an exploratory study such as this, it is worthwhile for strategists and academics to trace the complexities of work shown throughout this thesis. It is also the case, perhaps, that the social costs of mental health work are left incomplete or largely unexplored. Dramatic reconsiderations of the practical and operational aspects of mental health work are needed. So too, is a further acknowledgement of the intricacies of informal work practices and the expectations placed upon staff. Indeed, many informal practices may well oppose regulatory standards,

however an understanding of the reasons why formally sanctioned rules are circumvented can inform upon these organisationally defined expectations in the first instance.

Limitations

As has been raised earlier, Goffman (2007, p.8) in his study of the psychiatric patient noted that he took a 'partisan view' of this group. This could well be said for this study (in light of the worker) also, and that it has only presented a partial view of work and social systems within mental health services. Management and their structures have come under some scrutiny by participants in this study and yet their (management's) personal views have not yet been expressed. This would un-doubtedly be an opportune avenue to pursue in the future, and would further provide a balance to academic debates on the realities of contemporary mental health work.

Opportunities for the Future

Health services nationally, at the time of writing this thesis, are in a state of flux. The coalition government has announced broad reaching public sector financial cuts and large-scale reforms to the National Health Service. The future of some services is perhaps less certain, not least with the government decision to abolish Strategic Health Authorities by 2012 and Primary Care Trusts by 2013. Such radical reforms will engender new systems of financial management and thus the commissioning of clinical services will alter significantly. Under such dramatic shifts in political healthcare agendas, it is somewhat difficult to specify recommendations based on broad issues of governance; however, the exploration of the delivery of services undertaken in this thesis unveils a number of key and relevant issues.

A consistent issue evident from this research has been the rationality of policy and procedure from an operational and administrative standpoint. As services develop to maintain quality services on a limited budget, a constant barometer on staff experiences is necessary to meet with the needs of those who administer them. As an organisation develops, the informal work character of the organisation does too. Where a greater professional tolerance (for example, staffing pressures, efficiency pressures) is expected of staff, informal or subcultural work practices develop alongside. Where pressures become great, the informal structures of work are likely to become more sophisticated in response to organisational imperatives. Where this is the case, it is also likely that these informal mechanisms will carry a greater importance in the occupational lives of mental health workers.

The shifts in the occupational imagery and role set of clinicians and practitioners between that of bureaucrat and care provider is offset against mandates of both care and control. These obligations of work, albeit being ideologically opposed, structure the practical dimensions of contemporary clinical practice. The day-to-day management of such a situation is likely to take its toll on the attitudes and behavioural responses of the workforce. It is perhaps here, where guidance on the maintenance of a buoyant workforce is least informed and this study makes a contribution to unveiling the practical complexities of delivering modern services in the shadow of developed and developing symbolic and ideological debates.

APPENDICES

Appendix (i)

Overview of Prison Officer Typologies

Kauffman's (1988) Prison Officer Typology

Pollyannas

Kauffman (1988) describes *Pollyannas* as a discreet few amongst officers. Getting along with both staff and inmates simultaneously was seen as near impossible by other officers.

White Hats

White Hats were labelled as 'goody two-shoes' within the officer subcultures. Kauffman (1988) describes these officers as having a great deal of compassion for inmates but at the same time a distain for colleagues who they saw to have changed after years of working and losing the compassion for the inmates.

Hard-Asses

Hard-Asses were typically young and inexperienced. Kauffman (1988, p.253) described this group as viewing 'violence as excitement' and of a 'special breed that derived satisfaction from their ability to exercise control by whatever means'. Kauffman (1988) witnessed that it was this type of officer who was responsible for transmitting the cultural values of officers which reinforced the problems of violence at one prison which was researched.

Burnouts

Burnouts were typically older generation officers who had in the past enjoyed the excitement of the job, but were now despondent about the job. Additionally, Kauffman (1988) noted that *Burnouts* were individuals who had joined the prison service and felt trapped because of their socio-economic constraints. Despite the job not fulfilling their expectations and 'surviving' (Kauffman, 1988, p.256) the daily shift, it was remarked by some that they fantasised of quitting but never did, they just continued with the job.

Functionaries

Kauffman (1988, p.257) viewed *Functionaries* as those who were 'free from illusions that they were serving any useful role in society....just maintaining the human warehouse'. Being ambivalent to each other and their surrounding was seen as an 'insulator', the only possible way of surviving and coping with the nature of the job

Carter's (1994) Prison Officer Typology

Black and Whiter

Black and Whiter refers to the group of staff who are recognisably socially distant from inmates. There is no visible interaction on a personal level and a distinct line of us-and-them exists. Carter (1994) illustrates how when interviewing officers on their opinions of prison disturbances, those fitting within a *Black and Whiter* typology saw that prison unrest was a consequence of 'relaxation of regimes and a liberalisation of imprisonment.' (Carter, 1994, p.46). These officers, as Carter (1994) describes are seen by colleagues as inflexible particularly evident in incident reporting. Detailing every minor incident to management was seen to undermine the ability of staff to control inmates, seriously affecting the occupational image of some sub cultural work groups.

Weathermen

Weathermen accounted for the majority of staff working at the prison. Within their work routine, they interweave elements of flexibility and fairness, with recognition of inmates as individuals. Inmates involved in the research study commented how these groups of officers were generally 'good screws' (Carter, 1994, p.52), with a certain level of mutual respect for one another.

Easy Lifers

Easy Lifers like Kauffman's (1988) description of *Burnouts* describes groups of staff no longer interested in their job. Strategies adopted were focused upon attempts to ignore the existence of inmates by way of using avoidance tactics such as being unhelpful in inmate requests and 'turning a blind-eye' to drug use on the wing.

Appendix (ii)

Interview Schedule

Interview Schedule for sub-session three

QUESTION	INTERVIEWER NOTES
<i>Background</i>	
What is your job/position on this ward/dept?	
How long have you been working in mental health care, and in your current position?	
Where else have you worked?	
What factors influenced your choice of occupation?	
Can you tell me what types of training are available to you?	
What kinds of training do you think are most important?	
<i>Nature of the department</i>	
How did you come to be working in this ward/dept.? Did you choose to come here? How do you feel about being here?	
How does this ward/dept. differ compare to elsewhere?	
Can you describe the ward/dept?	
Can you describe a typical day/night in this ward/dept?	
Do you think that there is a particular way of working in this ward/dept?	
Do you have a particular way of working? How does this compare with others that you work with?	
Do you feel part of the staff team here?	
What is your relationship like with others that you work with?	
How do you think other wards/depts. see this ward/dept?	
<i>Day-to-Day Running</i>	
Do you think that this ward/dept. runs smoothly for the majority of time?	
What may disrupt this smooth	

running?	
What are the means of dealing with situations that could disrupt the smooth running of this ward/dept? What may influence your decision on the course of action taken?	
Do you consider yourself to be a 'by-the-book' or 'flexible' worker?	
Your work, at time, requires you to provide both assessment and treatment, but also exert levels of control (e.g. MH Act). What personal qualities do you think are essential to balance your role between care and compassion, and authority?	
Can you describe and visible routines or habits that staff undertake which are integral in daily clinical practice?	
General	
Have you noticed any changes in the nature of your job?	
How is your work influenced by external faces e.g. politics	
You are working in an environment which is clearly challenging at times. What support is available to staff?	
What elements of your work and environment have affected your outlook on your role?	
Are there any distinct ways of responding to your work environment?	
Has your job influenced or affected your outlook on yourself and/or others outside of work?	
How do you deal with your own stress and emotions?	
Occupational & Family Relations	
In your workplace, is there a sense of solidarity, or is there potential for isolation?	
Are there any occasions where staff all get together either formally or informally?	
Do you ever 'take your work home with you'?	
What do you think your close family and friends think of you working where you do and doing	

the job that you do?	
Do you think that doing the type of job that you do affects in any way your social relations outside of work?	
Reflection	
How do you feel about your job role? Are you happy in your job?	
How do you view your role to have changed over your healthcare career?	
What are your expectations for the future?	
Is there anything about your job that you would like to see changed?	
Closing Questions	
Is there anything else that you would like to add about your experiences of working here?	
Is there anything further that you would like to ask about the research study?	

Appendix (iii)

Theme Development

Theme Development			Core Category
<div><div>1. <i>Limitations to autonomy</i></div><div>2. <i>Rapid development</i></div><div>3. <i>Community centred care</i></div><div>4. <i>Smoking Ban</i></div></div>	Policy Sanctions	Micro Level Influences	Bureaucratic Control
<div><div>1. <i>Loss of traditional methods of working</i></div><div>2. <i>Building new traditions</i></div><div>3. <i>New premises</i></div><div>4. <i>Reduced hospital occupancy</i></div><div>5. <i>Security systems</i></div></div>	Organisational Development		
<div><div>1. <i>Code of conduct</i></div><div>2. <i>Increase in positive risk taking</i></div><div>3. <i>Staffing pressures</i></div><div>4. <i>Expertise</i></div></div>	Accountability & Responsibility	Governing Mandates	
<div><div>1. <i>New ways of working policy</i></div><div>2. <i>Recruitment</i></div><div>3. <i>Retention</i></div><div>4. <i>Re-Deployment</i></div><div>5. <i>Retirement</i></div><div>6. <i>Rotation</i></div></div>	Staffing & Regulation	Changing Organisation Landscape	
<div><div>1. <i>Foundation Trusts</i></div><div>2. <i>Free market sale of services</i></div><div>3. <i>Financial restrictions to some services</i></div><div>4. <i>Financial injection to some services</i></div></div>	Finance		
<div><div>1. <i>Multi-managerial organisation</i></div><div>2. <i>Clarity of decision making</i></div><div>3. <i>Increased divide between shop-floor and managerial staff</i></div></div>	Hierarchy	Relationships	

Theme Development			Core Category
1. <i>Personal responsibility for other's behaviour</i>	Accountability	Risk to Practitioner	Risk Management
1. <i>Organisation saving face at expense of front-line workers</i>	Litigation		
1. <i>Assessing risk 'vs' efficiency</i> 2. <i>Resources & communication</i> 3. <i>Multi-agency practice</i>	Safety	Risk Standards	
1. <i>Health & safety</i> 2. <i>Policy adherence</i> 3. <i>Continued training and personal development</i> 4. <i>Changing nature of risk management</i> 5. <i>Changing nature of client populations</i>	Risk Aversion		
1. <i>Efficiency of client recovery</i> 2. <i>Reducing pressure on services</i> 3. <i>Challenges of psychiatric and psychological diagnosis in assessment of risk</i>	Positive Risk Taking	Delivery Pressures	

Theme Development			Core Category
<div><div>1. <i>Doing the job 'right'.</i></div><div>2. <i>Interpreting the rules of the job</i></div><div>3. <i>Acknowledging Achievement</i></div></div>	Occupational Effectiveness & 'FIRE-FIGHTING'	Informal (subcultural) Character of Work	Competence
<div><div>1. <i>Towing the Line & Pulling Weight</i></div><div>2. <i>Earning respect through challenging encounters</i></div><div>3. <i>Keeping the peace and maintaining the status quo</i></div><div>4. <i>Leadership &role models</i></div><div>5. 'SAVING FACE'</div></div>	Peer Regard		
<div><div>1. <i>Negative acculturation</i></div><div>2. <i>Formal & informal work practices</i></div><div>3. <i>Labelling & stigma of staff</i></div></div>	Attitude to Work & 'SHELF-LIFE'		
<div><div>1. <i>Colleague support</i></div></div>	Safety		
<div><div>1. <i>Promotion & 'acting up'</i></div><div>2. <i>Equality in opportunity to develop</i></div><div>3. <i>Assuming responsibility</i></div><div>4. <i>Do workers want to develop? New & old.</i></div></div>	Personal Development	Opportunities for the Future	
<div><div>1. <i>Access, funding & time</i></div><div>2. <i>Resistance to new practice</i></div></div>	Education & Training		
<div><div>1. <i>Concern over closure of services that are not financially efficient</i></div><div>2. <i>Staffing levels</i></div><div>3. <i>Extending generic roles</i></div><div>4. <i>Liaison with provisions from private sector</i></div></div>	Efficiency	Organisational Imperatives & their Practical Effects	
<div><div>1. <i>Personal accountability</i></div><div>2. <i>Complaints</i></div><div>3. <i>Litigious climate</i></div><div>4. <i>Blame culture</i></div></div>	Responsibility		

Theme Development			Core Category
<div><div>1. <i>Diversification of Diagnosis</i></div><div>2. <i>Development in Pharmacology</i></div></div>	Medical Model of Treatment	Governing Obligations	Morality
<div><div>1. <i>Moral good of a caring profession</i></div><div>2. <i>Unquestionable altruism</i></div><div>3. <i>Facilitating recovery</i></div></div>	Occupational Hegemony		
<div><div>1. <i>Limits to treating personality</i></div><div>2. <i>‘Good’ and ‘bad’ patients</i></div><div>3. <i>Fighting against societal evils</i></div></div>	Healing the Sick		
<div><div>1. <i>Protecting vulnerable people</i></div><div>2. <i>Protecting the public</i></div></div>	Administering Safeguards	Societal Obligations	
<div><div>1. <i>Unveiling the extremes of society</i></div><div>2. <i>Personal sacrifice to the job for the ‘greater good’</i></div></div>	Dealing with the Dangerous	Reflections on Society	
<div><div>1. <i>Expectation for violence but necessary for a positive overall outcome</i></div></div>	Danger in the Line of Duty		

Theme Development			Core Category
<div><div>1. <i>Masculinities</i></div><div>2. <i>Embedded historical traditions</i></div><div>3. <i>Keys replaced by technology</i></div><div>4. <i>Re-invention of 'total institution'</i></div><div>5. <i>'Wards in the community'</i></div></div>	<div>Symbolic Power & Control</div>	<div>Symbolic Consequences of Organisational Decision Making</div>	<div>Physical Environment</div>
<div><div>1. <i>Stigma of clients</i></div><div>2. <i>Stigma of Staff</i></div></div>	<div>Stigma</div>		
<div><div>1. <i>'Shelf Life'</i></div><div>2. <i>Labelling</i></div><div>3. <i>Inclusion & exclusion</i></div><div>4. <i>Being the right 'type' of person</i></div><div>5. <i>The 'working personality'</i></div></div>	<div>Enculturation, Acculturation & Socialisation</div>	<div>Informal (subcultural) adaptation and responses to social environment</div>	
<div><div>1. <i>Emotional labouring</i></div><div>2. <i>Job satisfaction</i></div><div>3. <i>Burnout</i></div><div>4. <i>Sickness absence</i></div></div>	<div>Staff Well-Being</div>		
<div><div>1. <i>Development of specialised 'saleable' services.</i></div><div>2. <i>Equity in dispersal of funding</i></div></div>	<div>Monetary Economy</div>	<div>Physical & Practical Outcomes of Organisational Governance</div>	
<div><div>1. <i>Changes based upon developments in technology and legislation</i></div></div>	<div>Policy Development</div>		
<div><div>1. <i>Evidence based responses to critical incidents</i></div></div>	<div>Safety Initiatives</div>		

Theme Development			Core Category
<div><div>1. N.I.C.E</div><div>2. N.I.M.H.E.</div><div>3. DoH</div></div>	Clinical Standards	Responsibility Frameworks	Care versus Control
<div><div>1. Mental Health Act 2007</div><div>2. Mental Capacity Act 2005</div></div>	Legislation		
<div><div>1. M.A.P.P.A.</div></div>	Public Protection		
<div><div>1. Criminal prosecutions</div><div>2. 'Working Personality' Policy</div><div>3. Police liaison</div><div>5. NHS Security management service</div></div>	Staff Safety	Protective Measures	
<div><div>1. Collaborative care planning</div><div>2. Advance directives</div></div>	Respect & Dignity	Procedural Obligations	
<div><div>1. Restraint</div><div>2. Observation</div><div>3. Escorted walks</div><div>4. 'Batch living'</div><div>5. Enforced Medication</div><div>6. Mental Health Act 2007</div><div>7. Restricted & locked accommodation</div><div>8. Diversity between roles e.g. nurses & therapists</div><div>9. Disciplines represent varying degrees of authority</div></div>	Authority	Practicalities of a dichotomy of practice	
<div><div>1. Protected therapeutic time</div><div>2. Delivery of assessment & treatment, occupational & talking therapies</div><div>3. Recovery planning</div><div>4. Hospitalisation as a place of safety</div></div>	Altruism		

Appendix (iv)

Trust Access Approval

Official letterhead removed for anonymity



Academic Unit

**Submission Point for Electronic
Approval of Research**

3rd July 2008

Mr Paul Taylor

Dear Paul,

Re: Research Governance Decision Letter

Unique SPEAR Identifier: 0707

Project Title: An Exploratory Study of the Occupational Culture(s) & Working Lives of
Mental Health Workers

Further to your request for research governance approval, we are pleased to inform you that this Trust has approved the study.

Trust R&D approval covers all locations within the Trust; however, you should ensure you have liaised with and obtained the agreement of individual service/ward managers before commencing your research.

Please take the time to read the attached 'Information for Researchers – Conditions of Research Governance Approval' leaflet, which give the conditions that apply when research governance approval has been granted. Please contact the R&D Office should you require any further information. You may need this letter as proof of your approval.

May I wish you every success with your research.

Yours sincerely

Research and Effectiveness Officer

cc : Research Governance Sponsor
Employing Organisation
Day to Day Contact for study (if applicable)
Principal Investigator (if applicable)

Enc: Approval Conditions Leaflet
Induction & ID Badge Information, TrustTECH Leaflet

Appendix (v)

Participant Information Sheet

Despite health workers not being seen as a 'vulnerable' research population, contingency arrangements are made in order to facilitate the participant in receiving any help which they may require. As a measure of good research practice, the relevant contact details of support agencies and occupational health services are available below.

OCCUPATION HEALTH DEPARTMENT

List omitted for
purposes of
confidentiality

TRADE UNIONS

Royal College of Nursing (Welfare) 0845 408 4391

UNISON (North West Division) 0161 211 1000

SUPPORT CHARITIES

SAMARITANS 08457 90 90 90

Social and Communication Studies

Participant Information

An Exploratory Study of
the Occupational Cultures
and Working Lives of
Mental Health Workers.

We would like to invite you to take part in a research study.
Before you decide you need to understand why the
research is being done and what it would involve for you.
Please take time to read the following information carefully.

Contact:
Paul Taylor
Principal Researcher
paul.taylor@chester.ac.uk



PURPOSE OF THE STUDY

Very little is known about the occupational culture(s) and working lives of mental health workers. The research proposed here aims to provide a sociological understanding of how mental health work is 'done' and the impact of mental health work on those who do it. The main technique of data collection will include interviewing staff members. Those who volunteer to take part will be asked to participate in a total of three interviews. The first will ask for an occupational life story and the following interviews will discuss what was explained in the first. The findings should be highly germane to policy debates around the recruitment and retention of mental health nurses (Department of Health, 2006), whilst also contributing to contemporary sociological analyses of work and employment.

WHY HAVE I BEING INVITED?

This study aims to gain participation from all levels of the multi-disciplinary nursing team through volunteer based interviewing, with your contributions forming the basis of exploring the social reality of mental health work.

DO I HAVE TO TAKE PART?

There is no obligation for you to take part; however your participation in interviewing would be much appreciated. There is no risk of reprisal if you decide not to take part or withdrawal of your consent during the research study.

WHAT HAPPENS IF I TAKE PART & WHAT DO I HAVE TO DO?

The study will visit various clinical areas within the Hospital and the Trust. If you choose to take part in interviewing, you will have the opportunity to tell the researcher your experiences of healthcare working, and the experiences that are most important to you. The second and third interviews will further build upon what was discussed in the first. All data will be made anonymous by the researcher, making it as difficult as possible for any workers participating in the study to be identified. Additionally, the name of the hospital, ward, department or team will be omitted from research findings, reports and the finished thesis.

Interviews will take place at a time and place that is convenient to you. Each interview would take a maximum of one hour to conduct.

WHAT ARE THE ADVANTAGES OF TAKING PART?

Those who take part in interviews will be provided with a platform from which they can voice their concerns, issues or praise for the organisation which they work within. The contribution to knowledge that grass rooted participants will facilitate has not only the opportunity to bring workers views into a contemporary academic domain, but also has the ability, that through their representation within the research, the possibility to inform and change current policy and practice.

WHAT ARE THE POSSIBLE DISADVANTAGES IN TAKING PART & HOW CAN I COMPLAIN?

Although it is not anticipated that participants would be harmed during the conduct of the research study, relevant contact information is available here in case of the need to seek professional advice or support.

Please approach the researcher in the first instance with any queries, complaints or issues requiring attention:

Mr Paul Taylor, Principal Researcher & PhD Candidate
Dept. Social & Communication Studies
UNIVERSITY of CHESTER,
Parkgate Road,
Chester, CH1 4BJ
Email: paul.taylor@chester.ac.uk
Tel: 01244 511237

If you feel that you wish to contact another University of Chester representative, please contact:

Dr. Cassandra Ogden, Academic Supervisor
Dept. Social & Communication Studies
UNIVERSITY of CHESTER,
Parkgate Road,
Chester, CH1 4BJ
Email: cogden@chester.ac.uk
Tel: 01244 512068

Appendix (vi)

Participant Consent Form



University of
Chester

Department of Social &
Communication Studies

Site Number.....

CONSENT FORM

Title of Project:

An Exploratory Study of the Occupational Culture(s) and Working Lives of Mental Health Personnel

Name of Researcher:

PAUL TAYLOR

**Please read the following and initial in the box on the right-hand side*

I confirm that I have read and understand the information sheet dated
..... for the above study. I have had the opportunity to consider the
information, ask questions and have had these answered satisfactorily.

☐

I understand that my participation is voluntary and that I am free to withdraw at any
time without giving reason.

☐

I understand that data collected in the study will be available to the researcher and any
identifiable information removed prior to thesis completion.

☐

I agree to take part in the above interview(s) of the study.

☐

I agree that the researcher may use direct quotations expressed by myself during
interviews subject to them being made anonymous.

☐

Please note: In the unlikely event that information disclosed during this study by participants that, in
the opinion of the research supervisory team, indicates occupational mal-practice then this information
will be passed directly to your line manager.

.....
Name of Participant

...../...../.....
Date

.....
Signature

.....
Name of Person Taking Consent

...../...../.....
Date

.....
Signature

Appendix (vii)

Recruitment Demographic

<u>Work Area Demographic of</u> <u>Participants</u>	Nurse		Clinical Support Worker		Occupational Therapist		Occupational Therapy Technical Instructor		TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	
<u>Ward/Department</u>									
Thames Ward (Acute Admission)	2	0	0	0	n/a	n/a	n/a	n/a	2
Humber Ward (Acute Admission)	1	4	0	0	n/a	n/a	n/a	n/a	5
Derwent (PICU)	0	0	0	0	n/a	n/a	n/a	n/a	0
Hayle (Older Peoples' Service)	0	0	0	0	n/a	n/a	n/a	n/a	0
Trent (Intensive Rehab)	2	0	0	0	n/a	n/a	n/a	n/a	2
Avon (Occupational Therapy)	n/a	n/a	n/a	n/a	0	3	1	0	4
Crisis Resolution Home Treatment	3	4	0	0	0	0	0	0	7
TOTAL	8	8	0	0	0	3	1	0	20

Appendix (viii)

Participant Summary Impressions

Participant Summary Impressions

As custodian of the interviews and transcriptions, the researcher is unable to provide the narratives of participants in a full manner due to ethical considerations. In order to provide additional depth and description that provides further context to the segments presented in the chapters of this thesis, below is a short background summary of each participant.

Name	S/N Dignan	Sex	Male
Position	Staff Nurse	Department	Acute Ward
Summary Impression			
<p>S/N Dignan has over forty years experience working in the field of mental health nursing. Some of this time has been spent working in general hospitals also, as S/N Dignan holds a dual qualification in nursing (RMN, RGN).</p> <p>He has worked in a variety of public and private care environments, with much of his occupational career being based within large county hospitals in the North West of England. S/N Dignan has occupational experience of the high-secure forensic setting also.</p> <p>During the earlier part of his career, S/N Dignan recalls how the function of large county hospitals was to provide care and treatment for large populations, usually in excess of two thousand patients on one site.</p> <p>He sees that this role was as much about being custodian of the hospital population as it was about providing treatments for symptoms. For this reason, S/N Dignan reminisces of how he saw himself as somewhat of an innovative practitioner during his career, where possible, acting as an advocate to the patient opposed to a his observations of his colleagues at that time.</p> <p>Over the decades, S/N Dignan has progressed through the nursing 'ranks', with its pinnacle being that of an advisory role for a large city health authority. He has invested time in his education during his working life, achieving both undergraduate and postgraduate qualifications in subjects related to his discipline.</p> <p>S/N Dignan provides a temporal reflection on the changes he has experienced across his career, ranging from diagnoses, patient populations and work environments. A great deal of time is spent in his accounts providing some illumination on the characteristics of how work was done across the work</p>			

environments he has experienced. He reflects heavily on hierarchical issues affecting him and those he has been part of. As S/N Dignan is closely reaching the end of his career, he makes comparisons between his styles of nursing compared to those of student nurses and those who have recently qualified. According to S/N Dignan there are frequent occasions where the interpretation of a clinical situation is opposed between him and others he works with, yet he relies upon his experiential learning in the main.

Name	S/N Tonry	Sex	Male
Position	Staff Nurse	Department	Rehabilitation Ward
Summary Impression			
<p>S/N Tonry came into the nursing profession later in his working life. He had worked in several manual occupations prior to this, which he found demoralising and unrewarding. Rather than an application straight to a School of Nursing, S/N Tonry decided that he would gain some experience of caring for the mentally ill as a care/support worker.</p> <p>This he did, and spent a number of years working in a variety of hospital-based and community roles before embarking upon university study for registration as a mental health nurse (RMN).</p> <p>S/N Tonry now works in rehabilitative setting where he feels happy and contented. He states that he feels little pressure from organisational changes but describes his observations of others across his previous positions. S/N Tonry describes how in previous roles, others in the staff team have been forced to adapt significantly and this has been observed to have taken its toll. S/N Tonry realises that the current financial and organisational climate is tentative, but chooses to remain optimistic about the future of his career as he sees little opportunity for staff at 'shop-floor' level to influence executive management decisions.</p> <p>S/N Tonry feels that he is well supported in his role and reflects that the team he works within is strong, stable and reliable. There are aspects of work where he feels that his 'hands are tied', for example problems engaging with clients due to smoking restrictions recently introduced. Despite this, S/N Tonry describes the ways of working in this environment as 'relaxed' and structured, which he sees as a direct contrast to the acute admission wards.</p>			

Name	S/N Hoy	Sex	Male
Position	Staff Nurse	Department	Acute Ward
Summary Impression			
<p>S/N Hoy describes that he ventured into a nursing career due to the influences of family members working in the profession. This, some years ago appeared common, as S/N Hoy comments that frequently family members worked in the same hospital.</p> <p>S/N Hoy trained as a registered mental health nurse (RMN) in the early nineteen-nineties at Hollybrook hospital. He describes his training as ‘thorough’ in contrast to what he believes training is now. Following this he decided to work in the private sector, spending a number of years working at a number of residential rehabilitation environments.</p> <p>The work that was undertaken in these private sector environments is described by S/N Hoy as challenging at times, a view not often shared by his hospital working counterparts. He perceives that those staff who have predominantly worked in a hospital environment think that the private sector is easy and straight-forward. S/N Hoy embellishes on this with some stories of critical incidents occurring whilst he was on duty.</p> <p>S/N Hoy, who moved back to work at Hollybrook hospital in 2000 and feels that the hospital setting is much more supportive than the environments he had experienced previously. Yet S/N Hoy describes how staff surrounding him is continually ‘moaning’ about a lack of resources. This appears to anger S/N Hoy as he feels that there is an abundance of support, training and structure in the NHS hospital setting opposed to that of the private sector.</p> <p>Despite feeling that his current work environment is less stressful than previous clinical settings, S/N Hoy feels that policies and procedures are significantly over-bearing on those who deliver care and treatment. S/N Hoy feels that he is constrained in his autonomy by developing risk management strategies, and that such constraints leave workers developing a role that mechanised and ‘robotic’ rather than the personal nature of the caring professions.</p>			

Name	OT Gannon	Sex	Female
Position	Occupational Therapist	Department	Occupational Therapy
Summary Impression			

OT Gannon reflects that this is her second career and has been working as an occupational therapist since 2000. Her work has predominantly been based in Hollybrook hospital in junior and senior roles.

OT Gannon experienced work in both the current new hospital accommodation and the old Victorian buildings. She also worked alongside many staff who have since retired or moved away from the department.

OT Gannon reflects about the importance she has placed over her career on the ability to be accepted by colleagues and co-workers. Throughout her occupational experience, this has been central to stability in her role. Where she has been promoted into roles that others have left, she remarks that there was often a 'big pair of shoes to fill'.

Importance is placed on occupational traditions, and for OT Gannon, many of these were lost when the old hospital was closed and all staff and patients relocated to new purpose built accommodation. There were redeployments of staff and new surroundings. In addition to this there were frequent additions to policy and procedures that staff were obliged to adhere to and be flexible about. OT Gannon remarks about some of the personal effects of this on her own well-being, and feels that this period of time was extremely stressful for her.

OT Gannon describes how in light of new surrounding and new policies, there are new and developing ways of working. Within this, there are new traditions being forged, yet this is a problematic issue for many, as not all staff are willing to undertake this process of adaptation.

A main feature of OT Gannon's narrative illustrates her fondness of traditional hierarchical structures at ward level. The routine activities of staff and interventions that promote structure are seen to maintain a safe work climate, where-as OT Gannon sees that there is potential for the climate of work to become chaotic and fragmented if 'new lines of support and communication' are not developed.

Name	S/N Croall	Sex	Female
Position	Staff Nurse	Department	Acute Ward
Summary Impression			
S/N Croall provides a longitudinal account of her experiences of working in psychiatric services since the age of sixteen, some thirty-five years ago. A large part of her interviews are spent making comparisons between her occupational experiences past and present. S/N Croall indicates that, for her,			

working life in the 70s, 80s and 1990s was much more ‘straight forward’ than her experiences in the 21st century. She describes her approaches to work as embedded within a cohesive staff team, where hierarchy was respected and support in precarious situations abundant. In making contrasts to her contemporary work, this component appears diluted and procedural (and she explains this in the context of the Psychiatric Emergency Team), where some staff are reluctant to support colleagues in the workplace.

For S/N Croall, she is of the opinion that at a ward-level, hierarchical structures have diminished and become less visible; in turn this has led to considerable ‘back-biting’, which is somewhat out of control.

Risk aversion and risk management policies are viewed by S/N Croall as an obstacle to engagement with service users. Her interviews reflect a nostalgic component that describes the utility and importance on ‘outings’, holidays and fancy dress parties with service users. Her view now is that the relationship between nurse and service user is more conservative and built around predicting possible risks rather than engagement on a therapeutic level.

Name	S/N Thomas	Sex	Female
Position	Staff Nurse	Department	Acute Ward
Summary Impression			
<p>S/N Thomas has worked for over twenty years in nursing, she has spent time working in a variety of inpatient settings including nursing individuals with intellectual disabilities and community nursing.</p> <p>S/N Thomas reflects that in her mind, nursing has lost it’s ‘voice’. In this she explains that through increased focus upon the service user decisions in the care process and the restricted consequences to those who use alcohol and drugs in the clinical environment. She feels that nursing staff’s opinions are perhaps overlooked when incidents such as alcohol and illicit drug use on wards occurs. Through ‘client centred approaches’, nursing staff are powerless to reconcile a settled ward environment.</p> <p>In particular, S/N Thomas discusses her experiences of administering no-smoking protocols in the ward environment, stating that she had been assaulted by male service users when confiscating cigarette lighters. According to S/N Thomas, despite senior executives wishing such protocols to be enforced, the full consequences for staff are not fully understood.</p> <p>It appears that progressive policies and managerial influences have affected S/N Thomas’s outlook on her role. Coupled with changes that she has observed in the patient landscape, (for example, she states that she cares for</p>			

more drug-related symptoms now than she ever has done) S/N Thomas raises her frustrations with modern psychiatry and sees little opportunity for staff to be influential in deciding the next directions that hospital based care will take.

Name	OT Burton	Sex	Female
Position	Occupational Therapist	Department	Occupational Therapy
Summary Impression			
<p>OT Burton describes her work as varied and complex. She has worked in a variety of clinical settings, not least due to the structure of Basic Grade rotation schemes. Despite working in general health settings, OT Burton has been drawn towards mental health care due to the nature of group and individual interventions. Her work bridges across the inpatient and community setting, and she is able to support those discharged from hospital in the community despite much of her work taking place within an inpatient setting.</p> <p>OT Burton places an emphasis on how her work has changed over the course of her ten year career. According to OT Burton, there has been a shift in the character of occupational therapy interventions. It is often the case that interventions take place mainly on an individual basis, rather than group sessions. OT Burton illustrates this point by explaining that the types of patients that are hospitalised have changed over the last five-or-so years. Those that are hospitalised often only remain in hospital for a relative short time and at a point in their illness where symptoms are at their most acute. In this context, OT Burton describes the difficulties in being able to engage with a hospital population that is mainly in severe and acute stages of illness. Those has reflected the types and range of interventions being offered and considerable more time is taken in engaging and encouraging service users to take part in occupational therapy sessions.</p>			

Name	S/N Carrington	Sex	Male
Position	Staff Nurse	Department	Intensive Rehabilitation Ward
Summary Impression			
<p>Nurse Carrington sets his interviews in the context of a broad ranging occupational experience across three decades. He makes constant comparisons between his contemporary work and his experience in a variety of settings including prison nursing.</p>			

Nurse Carrington places an importance on the symbolic control component of his work, identifying that across his experience, control and security have been pivotal influences in all aspects of his work. He also describes how technological advances shroud traditional control mechanisms of the hospital (for example, locked doors and keys), but remain salient issues of everyday life.

Acceptance into staff teams has always been an important dimension to his career. He understands this in terms of being able to (a) work effectively (b) be respected by colleagues, and (c) important in career progression. He explains that being 'accepted' into a workplace is perhaps less important now than it had been previously. Nurse Carrington describes the work environment as less conducive to team work and that new staff, in particular student nurses, consider acceptance as a less important component of work.

Nurse Carrington looks fondly upon the early years of his career, and early career progressions. He sees this time as one where he felt that his opinions and judgements were well respected by all staff. In addition, he feels that the atmosphere that can produce effective staff teams has been lost since the move to new hospital premises.

Name	CSP Chapman	Sex	Female
Position	Community Specialist Practitioner	Department	Crisis Resolution Home Treatment Team

Summary Impression

CSP Chapman, in addition to providing insight into the range of posts she has held, identifies what she considers as stark contrasts in nurse training. A significant focus of her narratives discusses the challenges nurse training must contend with in order to meet with the developing context of contemporary work. CSP Chapman identifies that this was particularly difficult with the advent of 'Project 2000' nurse training. CSP viewed that students who trained within this programme were challenging for staff mentors to work with due to limitations in their knowledge base and practical/structural developments in contemporary care. CSP Chapman reflects that there were several problems in practice mentors being able to communicate with the School of Nursing effectively, however in recent years; she believes that there has been considerable improvement in the standard of nurse students in placement areas.

A further focus of CSP Chapman's interviews explains some of the challenges she encounters with the change in services, team structures and redeployment of staff. For her, these measures have produced systems that are unstable and work within an atmosphere of uncertainty for the future.

Name	CSP Churchill	Sex	Female
Position	Community Specialist Practitioner	Department	Crisis Resolution Home Treatment Team
Summary Impression			
<p>CSP Churchill has worked in a variety of roles within health services. She commenced her nurse training in the 1980s and has worked broadly across both inpatient and community services. Her experience of work within densely populated urban areas and more rural environments has provided CSP Churchill with a range of skills that she has developed, not least the ability to manage high turnover of service users within services.</p> <p>CSP Churchill reflects frequently during her interviews over the importance of maintaining her professional identity, and she believes that previous roles to her current one may have, if she had continued in that role, jeopardised this. She has been conscious to move roles when she feels that her skills are not developing, or her interest in a particular specialism has reached a plateau.</p> <p>CSP Churchill has an array of experience within a number of NHS Trusts through her career and has been somewhat nomadic in her employment. She believes that this has contributed positively to her clinical practice as it provides her with a broad repertoire of clinical and interpersonal skills.</p>			

Name	CSP Watts	Sex	Male
Position	Community Specialist Practitioner	Department	Crisis Resolution Home Treatment Team
Summary Impression			
<p>CSP Watts commenced his training in the 1990s and has trained and worked across a number of hospital sites. He has occupational experience of caring for a diverse client group including forensic services.</p> <p>CSP Watts places a great deal of emphasis on the ability to engage with clients in a therapeutic manner, particularly where there is opportunity to do so in the inpatient setting. Drawing from his own experience of inpatient nursing care, he strongly believes such an environment provides opportunity to talk and listen at length to the issues of service users, and this should not be governed by routinised activities or time limited.</p> <p>For CSP Watts, he reflects that he is able to make firm divisions between his</p>			

home life and work life. He is conscious to do this for his own well-being and in order to maintain an appropriate work-life balance. Despite his best efforts, he does acknowledge that this is not always possible, yet it is evident that his attempts to do so are a salient feature of his attitudes to work and home.

CSP Watts critically reflects upon his own role and that of others. He shows concern that those who work predominantly within one area or speciality succumb to the effects of working with one particular client group, and that their practice can be negatively influenced by this. He advocates that staff should experience a range of disciplines and environments to develop their practice.

Name	CSP Wakefield	Sex	Male
Position	Community Specialist Practitioner	Department	Crisis Resolution Home Treatment Team
Summary Impression			
<p>CSP Wakefield's narrative describes his occupational career both through his work in the hospital environment and then later in the community setting. He develops his work life history around the central issues of a dislike for care and treatment delivery in the restrictive context of the hospital environment. He favours the less restrictive contexts of rehabilitation and community working. His period of work in rehabilitation remained based within a large hospital building, yet there was frequent opportunity to arrange trips and visits for service users in a structured programme of community reintegration.</p> <p>CSP Wakefield describes some of the characteristics of work within a large hospital during the nineteen eighties, such as being left in charge of a ward on his own at night, yet, the feelings of camaraderie apparent within the hospital as a wider community.</p>			

Name	CSP Douglas	Sex	Female
Position	Community Specialist Practitioner	Department	Crisis Resolution Home Treatment Team
Summary Impression			
<p>CSP Douglas' career spans three decades and has taken place within a variety of geographical locations serving densely populated cities and more rural environments.</p>			

Her work in the past has involved both nursing and therapy provided by a nursing team, and she reflects fondly upon the opportunities the nursing staff had in these environments to build relationships with clients through this process. Her work has ranged in from acute care, challenging behaviour units and later community care.

CSP Douglas illuminates upon a number of events across her career that appear to have affected her practice in one way or another. The first of these was the first time she was assaulted by a patient, and the second was her return to using following a relocation and short career break.

CSP Douglas describes how the assault, at the time, was almost like a proficiency test of staff's resilience to the challenging nature of the work she was engaged in. Secondly, in a return to nursing following a break, CSP Douglas remarks in detail about the need to have a supportive team surrounding you as a prerequisite of successfully reintegrating into mental health work.

Name	CSP Cahill	Sex	Male
Position	Community Specialist Practitioner	Department	Crisis Resolution Home Treatment Team

Summary Impression

CSP Cahill's experience in healthcare has been drawn from two disciplines of learning disability and mental health. His introduction to mental health care was founded from experience with working with clients with primary diagnosis under the learning disability banner. In his interviews, CSP Cahill reflects upon the transition between the two disciplines, especially as he found significant differences which he did not necessarily expect (for example level of intervention, personal care and opportunity to open significant dialogue between service user and clinician).

CSP Cahill spends a large portion of his time discussing the ways in which he has 'fitted into' the areas of work that he has experienced. He describes how he was subject to the 'traditional' practices of working on acute admission wards when being newly qualified as a staff nurse, and only later being seen as competent to work alone. He reflects that the ward environment was an opportune learning environment as help, assistance and guidance was usually on hand immediately. He makes comparisons between this team working approach and his first role in the community.

CSP Cahill describes the transition between hospital work and community nursing as challenging and spends time describing how at times his confidence was challenged and through independent working, support was not as readily available as in his previous institutional roles. He describes how in actual fact,

the pressure to make judgements and decisions on a more independent basis was beneficial for self development, yet he also acknowledges the difficulties of doing so.

CSP Cahill goes on further to describe various socialisation processes that he has experienced through his career. Within his narrative, he highlights how in various teams and at various times, he has had to adapt his personality and practice in order to become accepted by the group. He describes this as being socialised into the status quo and reflects when observing team dynamics, some new-comers have been successful in this whilst others have not.

Name	CSP Hunt	Sex	Female
Position	Community Specialist Practitioner	Department	Crisis Resolution Home Treatment Team
Summary Impression			
<p>CSP Hunt's career in mental health is complimented by previous experience of work within a general health setting. She makes comparisons during her interviews about the differences that underpin the two disciplines. CSP Hunt describes her experience of general nursing as being 'mechanised', 'stiff' and 'old-fashioned'. Through training, CSP Hunt was able to experience the mental health environment, and from this, she decided to train in psychiatry.</p> <p>Her reasons for choosing psychiatry over general nursing was that she describes psychiatric care as a profession that is more 'people based' with adequate opportunity to engage interpersonally with the patient.</p> <p>CSP Hunt describes some of the social dimensions to her career in psychiatry. She describes her work within the hospital environment through the 1980s and 1990s suggesting that there was a strong sense of community amongst the staff groups. Furthermore, CSP Hunt describes how a large part of her career was spent working night shifts on hospital wards, where she describes that night staff were a 'community within a community'.</p> <p>Autonomy and competence as a practitioner is highlighted in CSP Hunt's interviews, in particular where she describes how nursing was structured during night-time hours. She states that in the past, nurses were frequently left in charge of a ward on their own. Such responsibilities are described as challenging, yet confidence and comfort were obtained through the knowledge of 'help at the end of the telephone'.</p> <p>In recent years, CSP Hunt has worked within the CRHT team and she reflects that her decision to undertake such a role was based upon a wish to face a challenge in a clinical area that she had not experienced before. She describes a variety of challenges that her and her colleagues face, both clinical and</p>			

organisationally, in particular raising concerns over the potential for political expedience in the health service and the future of clinical services. She poignantly suggests that the future of the NHS may well represent a gradual 'privatisation through the back door'.

Name	OT Wetherby	Sex	Female
Position	Occupational Therapist	Department	Occupational Therapy
Summary Impression			
<p>OT Wetherby has worked within occupational therapy for over two decades. Her interview begins with some reflection upon the issues that informed upon her decision to work within the field of mental health and psychiatry. She states that there were a number of influences, for example, her experience of volunteering with the mentally ill, friends working in the profession and friends who had used or come into contact with services.</p> <p>In addition to this, OT Wetherby describes how she felt that she has a creative tendency and was discouraged by psychiatric nursing as she could not envisage herself enjoying delivery of physical care.</p> <p>OT Wetherby has worked in a number of locations and for different care providers, yet she has consistently worked within teams that have a close working relationship with nursing staff. She feels that this is crucial to promote multi-disciplinary working to the advantage of the client. During interviews, it is evident that OT Wetherby places significant importance in the integration of disciplines and she appears frustrated with discipline divisions within services. This comes to light as she describes how predominantly her role, over her career, has been to observe social influences upon the patient's condition, rather than just pharmacologically. She appears as an advocate for open and integrated relationships between therapy and nursing teams in order to manage presenting issues effectively. In doing so, each profession has opportunities to learn from one another.</p>			

Name	TI Pervis	Sex	Male
Position	Technical Instructor	Department	Occupational Therapy
Summary Impression			
<p>TI Pervis has, like others working in Hollybrook hospital, experience of working in both the ward environment and therapy services. His interviews highlight some of the comparisons between the two disciplines as well as an observance of the pace of change in his immediate work environment.</p> <p>Sections of TI Pervis' interviews describe how members of the hospital staff socialised frequently together as well as working alongside one another. For him, this reflected the sense of staff community in the workplace; however he also acknowledges that for some, this may be exclusionary. Again, like other participants have highlighted, 'fitting in' the staff group can be problematic and those new to an environment at times will have to adapt personally and professionally in order to do this successfully.</p> <p>TI Pervis' current role allows him some freedom of integration between the nursing and therapy team, as he is responsible for supporting a number of in-patients. It is evident through his interview narratives that he enjoys this integration as it can help to break down 'professional boundaries' and 'gets your face known on the wards'.</p> <p>TI Pervis reflects broadly that he would very much like to consider his work as a vocation and long-term career, however appears anxious that the future restructuring of health services and organisational arrangements that are out of his control may jeopardise such long-term aspirations.</p>			

Name	S/N Peterley	Sex	Female
Position	Staff Nurse	Department	Acute Ward
Summary Impression			
<p>S/N Peterley commenced her nurse training in the mid 1970s and has worked in several large hospitals across the country over her career. Her interviews largely consist of a longitudinal reflection over her career where she makes comparisons across time and environments.</p> <p>S/N Peterley spends substantial time reminiscing about her work in psychiatry during the 1970s, 1980s and early 1990s. She experienced major transitions in care delivery; in particular she describes the influence of community care</p>			

agendas and the closure of large parts of the hospital she was working within. S/N Peterley describes, in depth, the process of deinstitutionalisation and reflects upon the challenges of this for both staff and patient. Attention is paid to the fragmentation of staff groups at this time in the 1990s, and she situates this within her deliberation over more recent changes in work teams and environments.

Like many, S/N Peterley describes how her experience of working within a number of large institutions during her career, appeared to foster strong staff relations and communities. Her analysis of work teams seems to suggest that it has become much more complex to establish strong teams in light of the challenges that modern psychiatry experiences.

Furthermore, S/N Peterley describes eloquently how frequently she has been forced to 'bite her tongue' in order to maintain a 'professional' persona and fulfil her role within a public service. Her interviews allude at various intervals about how she manages her 'on stage' performance and how she gains support from her colleagues and family.

Name	S/N Rumsey	Sex	Female
Position	Staff Nurse	Department	Acute Ward

Summary Impression

S/N Rumsey's occupational background stems from originally working within the confines of the hospital environment, then a move to community work and then a return to acute ward nursing. Her interview includes some of her observations of her past experiences of managing risk, where she describes risk assessment in the community nursing role she previously held. S/N Rumsey appears to have become frustrated on occasions with the levels of bureaucracy and paperwork attached to her role. She feels that, at times, governance surrounding risk management can be too restrictive, and impede upon the level of autonomy the service user has. S/N Rumsey describes the challenges of having to estimate and foresee risky behaviours and the potential consequences if she were to 'get it wrong'.

Concentrating on her role in the acute care setting, S/N Rumsey begins to describe how the character of the patient group has changed. However, she then goes on to suggest that in actual fact, perhaps little has changed from her past. She situates this deliberation in the context of drug and alcohol use in in-patient care, and asserts that a lot of the problems with illicit drug and alcohol use on the wards are no different to what it has been in the past. S/N Rumsey states that nursing staff have always had problems controlling contraband but must make concerted efforts to challenge patients who are involved in their presence on the ward.

Like others, S/N Rumsey discusses the imagery of nursing staff and the need to be observed as professional. She clearly demonstrates an acknowledgement of emotion management where she suggest that personal feelings need to be 'set aside' in order maintain levels of control in challenging situations.

Name	S/N Weaver	Sex	Male
Position	Staff Nurse	Department	Acute Ward

Summary Impression

S/N Weaver's occupational story begins with his nurse training during the 1980s. He describes how he had worked as nursing auxiliary in general care before embarking upon psychiatric nurse training. He reflects that psychiatry was more suited to his personality of being able to spend time talking with the people he was looking after. For him, general care was too much like a 'conveyor belt' of physical interventions such as 'emptying catheter bags and bed baths'. Furthermore, although S/N Weaver did enjoy some aspects of general nursing, he was compelled to the psychiatric discipline as he preferred an environment where there were more male colleagues in the team.

S/N Weaver has mainly worked in the acute ward environment throughout his career. He reflects that its unpredictability maintains his interest and offers a firm basis for self development through the adaption to new and ever changing situations. He does, however, provide an analysis of the effects an environment can have upon staff.

S/N Weaver presents as an individual who is cautious of the effects an environment and the professional role can have upon a clinician. He describes how over his career, he has witnessed other nurses personality and behaviour become 'hardened' due to what he sees as challenges of the job. S/N Weaver is concerned that some clinical staff may succumb to the pressures around them and this may change their outlook on their role. He describes that his own self protection against this is good 'self reflection' and 'good colleagues who will tell you if something changes'.

S/N Weaver describes some of the frustrations that are not new but continue in his current work. It appears that these frustrations are situated within the authority dimension of the job role, where nursing staff administer particular sanctions upon detained patients. He describes how at times, he continually says 'no' to patients, when he would like to say 'yes'. However his occupational responsibilities guide his decisions and he appears to envy, to some extent, those disciplines who say 'no' (or administer sanctions) to patients less frequently (for example, occupational therapy).

Appendix (ix)

Ward/Department Overviews

Acute Admission Wards

Two acute admission wards (Thames and Humber) operate at the research site. One has a capacity for eighteen service users, the other twenty. Within their remit, one will accept service users over the age of 65 who have functional mental health problems (Thames); the other caters for adults up to age 65, but also is allocated assertive outreach team (AOT) clients (Humber). Both wards will accept service users upwards of the age of sixteen years into a mixed sex environment. There is a constant attempt to maintain both skill and gender mixes amongst staff on duty. Each ward operates on approximately twenty-five staff.

The premises are modern with all service users having their own room with ensuite facilities. The wards are staffed with a mixture of band 5 staff nurses and band three clinical support workers. There are also two clinical lead (band 6) on each ward, and a manager (band 7) on each ward. Typically wards operate with up to five staff on duty, and at night three.

There are no designated teams on either wards, and staff work their shifts without any specific rolling rota. Ward staffing is also complimented by supernumerary nursing students. Personal alarms are worn by all staff at all times and render the assistance of an allocated psychiatric emergency team (PET) made up from a staff member from other wards. The purpose of the psychiatric emergency team is to deal with situations which may arise in a safe manner utilising prescribed techniques of care and responsibility³⁵ (C&R) where necessary. These situations may include; enforcing medication on a detained service user, stopping absconding and/or dealing with violence and aggression.

Admission to the acute wards will usually be via the Crisis Resolution Home Treatment Team (CRHT) or by the consultant psychiatrist or more junior medical staff. Service users may be bailed to the hospital pending psychiatric reports, or directed to the acute wards by the courts for an interim period, transfers from prisons may also occur. In the words of respondents, the acute wards at this local unit may well be regarded as something of a 'mother ship' in terms of the diversity of service users who may be admitted for assessment or treatment and the routes for discharge or referral to alternative services.

³⁵ Also previously known as control and restraint.

- ***Thames & Humber Acute Admission Wards***

Thames ward has, so far, remained unaffected by service remodelling and has maintained a core group of staff who have worked together for a number of years. As other wards and services have closed and changed, Thames ward has acted an environment to redeploy and decant surplus nursing staff. According to respondents from this ward, this has both helped and hindered the team in ways which will further be discussed later within this thesis.

Thames ward may be considered as being dominated by a highly experienced, but aging workforce. Several members of staff are approaching retirement age within the next couple of years, and some have returned to work as part-time staff following retirement. Ward management has changed twice over a five year period; however, clinical leadership has remained stable as both clinical leads (previously known as deputy ward managers) have remained in their posts for more than eight years to date.

Humber ward has perhaps endured the least amount of change or disruption, as services here have not been altered to any great extent.

Personally I think that morale on this ward is better than elsewhere in the hospital. The main reason is that a lot of wards have been messed about and closed and people moved. But we have never had that problem, we have never been moved and we have never been shut. We haven't had the pressures that some of the wards have.

(Staff Nurse Hoy; Thames Acute Ward, Humber Ward)

The nursing team has appeared to remain almost static throughout the structural changes of recent years, with re-deployment to this area being minimal. Leadership on this ward has been continuous in excess of ten years and those who have undertaken roles of clinical leadership (previously known as deputy ward managers) have emerged from the Humber ward staff team. In comparison to Thames ward, Humber ward may be characterised by a younger workforce of staff nurses with many being aged in their twenties, thirties and early forties.

Both wards are large and spacious, with accommodation for twenty (Thames) and eighteen (Humber) service users, each with their own en-suite room. There are numerous rooms for sitting, talking privately, taking part in activities and socialising with other service users or staff. Dining is communal, and the staff discourages service users from eating alone in their rooms.

Both admission wards, as with other areas of the hospital operate an electronic fob system of entry through main ward doors. These fobs replace keys, and each fob can be assigned electronically to open a chosen set of doors (for example, staff fobs will open all doors, service user fobs are

limited to specific areas, for example, their own room). Main ward doors remain locked, and entry can only be made by using a correctly assigned fob, or ringing the door bell. Service users are all given a fob of their own which is mainly used to open their own side-room. A risk assessment is conducted by nursing staff to whether their fob will be assigned to provide access to the main ward doors. This assessment will be based upon several indicators such as; time spent in hospital, legal status of the service user (Mental Health Act 2007), level of therapeutic observation and assessed level of risk of harm to self or others. The extent to which access can be made is continually under review by nursing staff and those who can leave the ward are asked to inform staff (verbally and a written record) of where they are planning to go and when they expect to return.

Derwent Psychiatric Intensive Care Unit (PICU)

Derwent PICU is a seven bedded intensive care unit for service users who are acutely unwell and requiring a low stimulus environment. The unit also functions in a manner which allows for a level of, not only care, but also security to be achieved via locked doors, fenced garden and safe-care/seclusion. Staff to service user ratios are high, with a typical staff number being five for seven service users.

Derwent PICU is managed alongside another PICU within the Trust. Together these PICUs provide services for the four mental health admission units within the Trust's geographical area. Additionally, these PICUs will market beds to other NHS Trusts dependant upon bed occupancy and a dedicated manager undertakes this task.

Referrals to PICUs from admission wards are reviewed by nursing staff, however, non-hospitalised service users may be transferred directly to the PICU environment following assessments in the community or transfers from the courts or custody. The two PICU units work alongside one another in terms of bed availability, and recently are both under single management.

Service users entering the PICU environment may be experiencing an acute phase of their illness. Management of their symptoms is assertive, and almost all clients will be detained under the Mental Health Act 2007. Service users residing in a PICU do not have fob access to main ward doors, and movement outside of the ward is usually with the presence of a nurse escort. Violence and aggression is managed both in terms of the number of staff, but also 'safe care'/seclusion facilities are available within the ward. The staff team on Derwent PICU is eclectic and is made up of a range of both new and old staff but is very much witnessed by others working within the hospital as quite insular in terms of the relations with the acute admission wards.

Hayle Older Persons' Ward

Hayle ward provides nursing services to men and women over the age of sixty-five suffering from organic diseases and disorders, for example;

Alzheimer's disease and vascular dementia. The needs of services users are complex and require significant attention by nursing staff toward both physical and mental health needs. Hayle ward has twelve beds and takes admissions from the community, residential homes and nursing homes in the main.

Staff on Hayle ward are the only staff within the hospital who wear a nursing uniform. This is considered to solve a practical problem of soiled clothing during work, but also to provide some clear delineation so that nursing staff are more easily recognisable for their clients. In many ways, the work on Hayle ward is aligned more with general nursing than any other ward in the hospital. The ward is considered as 'heavy' at times in terms of the manual handling requirements, toileting, and physical and mobility needs of clients. Service users range from those who are quite subdued, to those who actively assault staff and attempt to leave the ward.

Service users who are discharged from Hayle ward invariably return to the nursing home environment. At times this may be an economic and logistical problem as the needs of some are particularly complex and fall into 'continuing healthcare' criteria³⁶. The number of complex care beds in the community is limited and placement can become difficult in order to meet the needs of the service user. The consequences of this may well be that clients of Hayle ward are not discharged as soon as appropriate, but are delayed by bureaucratic measures (for example, funding applications) and enough appropriate placements for a growing aging population.

Trent Intensive Rehabilitation Unit

Trent ward is a relatively new facility at the hospital. It is primarily funded by the Primary Care Trust (PCT) in order to provide a two-year intensive rehabilitation function for service users with complex needs who would have previously been allocated to a private care provider. In the medium to long-term, financial savings can be made by the work carried out on Trent ward rather than the increased costs of a placement with private care providers.

Trent ward has a fifteen bed capacity (ten male, five female) and is physically divided by locked doors into male and female accommodation. Each part of the unit has its own facilities for example kitchen, lounge and activity room, and service users mix during activities such as barbeques and outings. Service users engage in planned programmes with staff both on the ward and out in the community and the nursing staff are complimented by a designated Occupational Therapist (OT) and two Technical Instructors (TI).

Main ward doors are locked, however, at this time; service users are not given access to the main doors on their own access fobs. It is necessary for service users on Trent ward to ask staff to be let on or off the ward.

³⁶ Continuing healthcare - ongoing financial support offered by the NHS to those with health needs as a result of disability, chronic illness or following hospital treatment.

More often than not patients are not refused from leaving the ward unless for good reason, but there still seems to be that sort of restriction so far as they are not free to just go out, they have to ask a member of staff for the door to be opened.

(Staff Nurse Dignan; Humber Acute Ward)

Trent ward was opened in 2006/07 following a spending review conducted by the Primary Care Trust (PCT). A programme of re-assessment of needs of those who had in previous years been placed in the private sector was undertaken. Those who were considered as appropriate for the operational philosophy of Trent ward (intensive rehabilitation) were transferred. The objectives of the ward are for service users to embark upon a two year intensive rehabilitation programme, after which they would be transferred to appropriate accommodation to meet their needs such as supported living or their own accommodation.

Trent ward was opened in the wake of the closure of a third acute admission ward that had witnessed widespread redeployments of staff. The staff team on Trent ward was a combination of applications and mandatory redeployment and there was great apprehension over the exact clientele which Trent ward would cater for. Divided accommodation, high-fenced gardens and double air-lock main doors raised rumours of 'dangerous' or forensic service users being managed within the hospital at the time. This apprehension and concern was soon quelled as the unit began to fill and the intensive rehabilitation programme achieved positive results.

Avon Occupational Therapy Service

Occupational Therapy is provided to Thames, Humber, Derwent and Hayle wards by the Avon Occupational Therapy service. This service consists of two lead occupational therapists, five specialist occupational therapists and five technical instructors. A range of activities are co-ordinated with the wards from Monday to Friday and include group and individual interventions. Groups such as creative writing, art, cooking, woodwork, gardening and ward groups are complimented with one-to-one work with clients.

Cognitive and spatial assessments are made and these contribute to the holistic multidisciplinary service provided. Occupational therapists from Avon are actively involved in the care planning and evaluation of each service user, regularly attending multidisciplinary meetings and ward rounds.

The nature of work undertaken by the Occupational Therapy department has had to adapt in recognition of the changes that in-patient services have experienced, yet the staff team has remained relatively stable. Staff report that their work is focused more now on one-to-one interventions rather than traditional large group activities. This is thought to be due to the ways

(including the Acute Care Model (ACM) and CRHT) in which in-patient care has a higher turnover of patients and there is a greater concentration of acutely unwell individuals occupying hospital beds in contrast to large numbers of delayed discharges and long-stay clients experienced in years gone by.

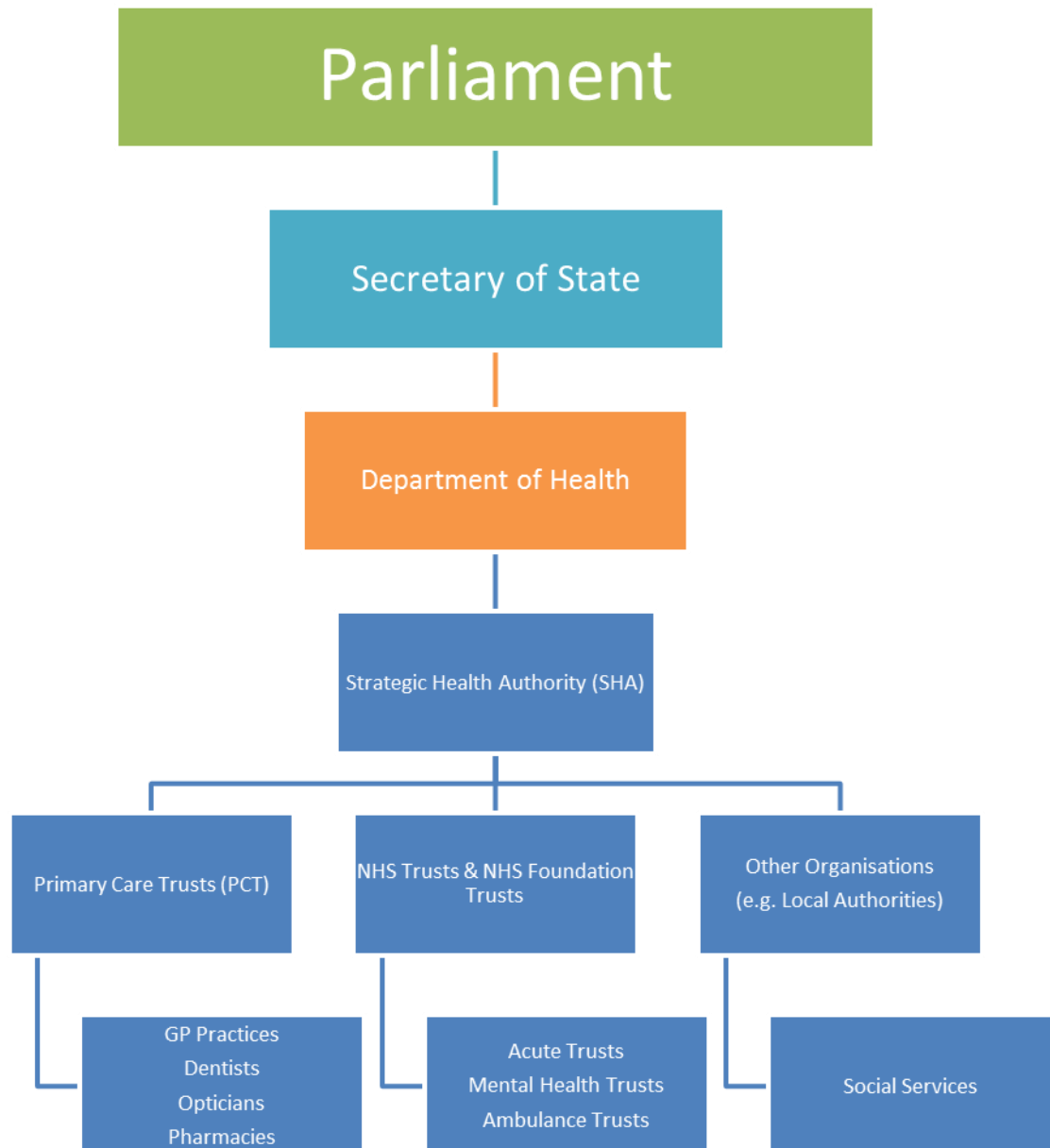
I feel my role has really changed since I have been working here. The type of people I see now appear to be much more acutely unwell than in the old hospital where there were lots of people who were not well but at the same time now be managed in the community. Now there isn't the opportunity to work at the same cognitive level as what I have done before.

(Occupational Therapist Burton; Avon Occupational Therapy Service)

Reports from nursing staff and occupational therapists suggest that during the organisational changes that this hospital has undergone, Occupational Therapy has remained as one of the 'constants' in the hospital regime despite their ways of working changing.

Appendix (x)

Bureaucratic/Structural Organisation of NHS Trusts



Appendix (xi)

Clinical Risk Assessment Example

CARDS Screening form

Purpose

To identify individuals for whom a full assessment of risk of violence or suicide is indicated.

Name of person being assessed:	Assessor:	Date:
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State whether the following indicators for both violence and suicide are present. They are intended to guide assessment – not to be added up or used to produce a numerical score.

VIOLENCE	Yes	No	SUICIDE	Yes	No
Significant past history of violence	<input type="checkbox"/>	<input type="checkbox"/>	History of previous suicide attempts	<input type="checkbox"/>	<input type="checkbox"/>
Current thoughts plans or symptoms indicating a risk of violence	<input type="checkbox"/>	<input type="checkbox"/>	Thoughts or plans which suggest there is a risk of suicide	<input type="checkbox"/>	<input type="checkbox"/>
Current behaviour suggesting there is a risk of violence	<input type="checkbox"/>	<input type="checkbox"/>	Suffers from a major mental illness	<input type="checkbox"/>	<input type="checkbox"/>
Current problems with alcohol or substance misuse	<input type="checkbox"/>	<input type="checkbox"/>	Current problems with alcohol or substance misuse	<input type="checkbox"/>	<input type="checkbox"/>
An expression of concern from others about risk of violence	<input type="checkbox"/>	<input type="checkbox"/>	An expression of concern from others about risk of suicide	<input type="checkbox"/>	<input type="checkbox"/>
<i>Also taking account of other relevant information, and the extent to which information is available to you, answer the final CARDS screening questions:</i>					
In your professional judgement, is a full assessment of the risk of violence indicated?				<input type="checkbox"/>	<input type="checkbox"/>
In your professional judgement, is a full assessment of the risk of suicide indicated?				<input type="checkbox"/>	<input type="checkbox"/>

Signature(s) of assessor(s).....

If you have answered No to both, then stop here (remember to file this form in the clinical notes).

If you answer Yes, complete the full risk assessment.

Clinical Assessment of Risk Decision Support (CARDS)

Health Services Research Department,
Institute of Psychiatry,
London.

Appendix (xii)

Overview of Pay Scales

Agenda for Change Pay Scale for Nursing & Allied Professionals 2010: Source, NHS Careers

Band 5

Point 16	21,176
Point 17	21,798
Point 18	22,663
Point 19	23,563
Point 20	24,554
Point 21	25,472
Point 22	26,483
Point 23	27,534

Basic Grade Occupational Therapist
Staff Nurse

Band 6

Point 21	25,472
Point 22	26,483
Point 23	27,534
Point 24	28,470
Point 25	29,464
Point 26	30,460
Point 27	31,454
Point 28	32,573
Point 29	34,189

Specialist Occupational Therapist
Clinical Leads / CRHT Practitioners

Band 7

Point 26	30,460
Point 27	31,454
Point 28	32,573
Point 29	34,189
Point 30	35,184
Point 31	36,303
Point 32	37,545
Point 33	38,851
Point 34	40,157

Occupational Therapy Lead
Ward Manager
CRHT Clinical Lead

Medical Staff (doctors) Pay Scale (2009): Source, NHS Careers

Junior Doctor (Level Two Foundation, SHO):	up to £41,285
Specialist Registrar (SpR):	up to £67,959
Consultant Psychiatrist:	£74,504 to £176,242

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